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	185256	A. BUILDING _____ B. WING _____	R 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW POST-ACUTE AND REHABILITATION CENTER	200 NURSING HOME LANE PIKEVILLE, KY 41501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Standard Recertification Survey was conducted in conjunction with an Abbreviated Survey investigating Complaint KY00033911, KY00033745, KY00034030, KY00034031, and KY00034032 beginning on 06/15/2021 and concluded on 06/19/2021. Complaint KY00033911, KY00033745, KY00034030, KY00034031, and KY00034032 were determined to be substantiated with deficient practice identified. Deficient practice was identified with the highest Scope and Severity identified at an "F" level. Census: 109. After supervisory review, the Standard Recertification Survey and Abbreviated Surveys investigating KY00033911, KY00033745, KY00034030, KY00034031, and KY00034032 were reopened on 07/27/2021, in conjunction with complaints KY00034173, KY00034237, KY00034238, KY00034299, KY00034400, and KY00034404. KY00034299 and KY00034404 were unsubstantiated. KY00033911, KY00033745, KY00034030, KY00034031, KY00034032, KY00034173, KY00034237, KY00034238, KY00034400 were substantiated and Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist, 05/18/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655), 42 CFR 483.25 Quality of Care (F684), and 42 CFR 483.80 Infection Control (F880). The facility was notified of the Immediate Jeopardy on 08/11/2021. The Immediate Jeopardy is ongoing. The facility failed to protect Resident #64,	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/04/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 Resident #86 and Resident #322 from abuse of Resident #82. Resident #82 displayed behaviors of exposing himself/herself numerous times to other residents, wandered in/out of other resident's rooms, and was verbally/physically abusive to other residents. The facility failed to implement effective interventions to prevent Resident #82 from abusing other residents. Resident #82's behaviors resulted in the following resident-to-resident abuse: On 05/18/2021, Resident #82 grabbed Resident #322 causing a skin tear; On 06/04/2021, Resident #82 grabbed Resident #64's wrist and would not let go; On 06/30/2021, Resident #317 held Resident #82's wrist because Resident #82 wandered into his/her room and would not leave; On 07/15/2021, Resident #82 hit Resident #86 with a shoe causing a large bruise to the resident's upper arm; and, On 07/31/2021, Resident #82 hit Resident #64 on the left wrist. Interviews with residents and staff revealed Residents #64, #86 and #322 were afraid of Resident #82. Interview with Resident #86 on 07/27/2021 revealed the resident was afraid to sleep because Resident #82 still came in his/her room and the facility had taken no action to protect the resident. The facility failed to develop a baseline care plan for Resident #321 and Resident #323 and failed to ensure the residents received treatment and care in accordance with professional standards of practice. On the morning of 07/18/2021, at approximately 7:30 AM, staff obtained Resident #321's blood glucose level, which was sixty-seven 67) mg/dL (milligrams per deciliter) (normal range 70 mg/dL to 110 mg/dL). Although the nurse held the resident's insulin injection, she administered the resident an oral hypoglycemic medication. The nurse stated after breakfast she re-checked	{F 000}		

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{F 000}	Continued From page 2 the resident's blood glucose level, which was then one hundred thirty-nine (139) mg/dL. However, there was no evidence the staff continued to monitor the resident or re-check the resident's blood glucose level, until sometime later that afternoon. Sometime after 3:00 PM, staff found Resident #1 unresponsive with a blood glucose level of forty (40) mg/dL. Interviews with staff revealed they administered Resident #321 both, injectable and oral glucose, and the resident regained consciousness. However, there was no documented evidence staff continued to monitor the resident's blood glucose level, until approximately 12:30 AM on 07/19/2021, when Resident #321 was found unresponsive and clammy. Interviews and record review revealed the resident's blood glucose was thirty-two (32) mg/dL. Staff again administered the resident injectable glucagon and oral glucose. Resident #321 remained unresponsive and developed difficulty breathing. The facility transferred Resident #321 to the hospital, where he/she was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. Resident #321 was admitted to the Intensive Care Unit (ICU). In addition, the facility admitted Resident #323, on 07/06/2021, after being on a ventilator at the hospital. At approximately 7:30 AM on 07/20/2021, a nurse aide entered the resident's room and discovered the resident was sweaty, clammy, and having difficulty breathing. Although interview with a nurse revealed she administered the resident two (2) breathing treatments, there was no evidence staff re-assessed the resident until the resident's family came to visit and insisted the facility transfer the resident to the hospital. Upon Resident #323's arrival to the	{F 000}		

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{F 000}	Continued From page 3	{F 000}		

hospital, the resident required high flow oxygen, and was diagnosed with acute hypoxic respiratory insufficiency, and left lower lobe pneumonia versus atelectasis (lung collapse).

Further, the facility failed to establish and maintain an infection prevention and control program to properly prevent and contain the spread of COVID-19 to Resident #314, Resident #311, Resident #327, Resident #82, Resident #325, Resident #328 and Resident #329.

On 07/24/2021, two staff members tested positive for COVID-19 at an outpatient clinic/hospital. Although, the facility was aware the staff tested positive, there was no attempt by the facility to determine which residents were exposed to the infected staff in an effort to isolate the residents to prevent further spread of the virus. In addition, the facility failed to immediately test residents for COVID-19 per the facility's policy. Residents were not tested until 07/28/2021, four (4) days after the staff members were positive. During the 07/28/2021 resident testing, Resident #314 and Resident #311 tested positive for COVID-19. However, the facility did not quarantine the residents to prevent the spread of infection to others until 08/05/2021, eight (8) days after the residents tested positive, when a plastic zip barrier was placed over the resident's doorway.

Further, the facility documented staff were routinely tested for COVID-19 on 07/30/2021. However, SRNA #13 stated she was not tested prior to starting her scheduled shift on 07/30/2021 from 6:00 PM through 6:00 AM on 07/31/2021. During her shift, at approximately 12:00 AM on 07/31/2021, she stated she started feeling sick while caring for residents. She stated she

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{F 000}	Continued From page 4	{F 000}		

reported her symptoms to the nurse who conducted a rapid COVID-19 test, which was positive. Again, there was no documented evidence the facility attempted to determine which residents SRNA #13 cared for during her shift.

From 07/28/2021 through 08/05/2021, an additional three (3) residents tested positive for COVID-19, Resident # 329, Resident #82, and Resident # 328. Resident #82 and Resident #329 were also hospitalized due to COVID-19.

Prior to the barrier being placed on 08/05/2021, Resident #325, who resided across the hall from COVID-19 positive residents, was observed walking in the hallways and sitting in a chair in the hallway adjacent to COVID-19 positive rooms. Resident #325 was not wearing a mask. On 08/08/2021, Resident #325 tested positive for COVID-19. On 08/09/2021, Resident #325 developed respiratory distress and was transferred to the emergency room and hospitalized. Resident #325 was readmitted from the hospital to the facility on 08/12/2021, and on 08/19/2021, Resident #325 developed respiratory distress again, and was sent back to the hospital where he/she expired on 08/26/2021.

One (1) additional resident (Resident #327) tested positive for COVID-19 on 08/07/2021, was hospitalized on 08/14/2021, and expired on 08/15/2021 at the hospital.

Immediate Jeopardy (IJ) was also identified, on 08/20/2021, and was determined to exist, on 03/23/2021, at 483.25 Quality of Care (F692). The facility was notified of the Immediate Jeopardy on 08/20/2021.

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{F 000}	Continued From page 5 The facility failed to ensure Resident #65, Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, Resident #81 and Resident #40 maintained acceptable parameters of nutritional status and/or body weight and failed to ensure their physicians were notified of weight loss. Review of Resident #65, Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, and Resident #81's medical records revealed each of the residents sustained significant weight loss due to the facility's failure to have a systemic procedure in place to monitor resident weight loss. The facility failed to obtain resident weights according to policy, failed to notify the Registered Dietitian (RD) when a resident sustained weight loss, failed to provide dietary recommendations to prevent further weight loss, failed to honor resident food preferences to prevent weight loss, and/or failed to ensure residents were served adequate portions to prevent weight loss. In addition, Immediate Jeopardy was identified on 08/27/2021 and determined to exist on 05/02/2021 at 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F656) and 42 CFR 483.25 Quality of Care (F686). The facility was notified of the Immediate Jeopardy on 08/27/2021. The facility failed to develop a comprehensive care plan to address Resident #65's pressure ulcer risk, failed to ensure Resident #65 received care to prevent pressure ulcers, and failed to ensure care and treatment was provided to promote healing, prevent infection and/or prevent	{F 000}		

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{F 000}	Continued From page 6 new pressure ulcers from developing. Resident #65 was admitted to the facility on 03/23/2021 without pressure ulcers. The facility failed to turn and reposition the resident as required. On 05/02/2021, Resident #65 developed a deep tissue injury to the coccyx. The facility failed to assess the pressure ulcer (measurements, appearance, drainage, odor, etc.) as required. Subsequently, the facility also failed to identify the pressure ulcer had worsened until 05/28/2021, when the resident was transferred to the Emergency Department (ED) due to worsening of the pressure ulcer. Resident #65 was admitted to the hospital for worsening sacral wound and was, "clinically septic with large decubitis [pressure] ulcer with associated infection including cellulitis and possible abscess". Resident #65 underwent surgical debridement on 05/30/2021, when all necrotic tissue was removed and "excision was down to the bone". Resident #65 was readmitted to the facility. However, the facility continued to fail to turn and reposition Resident #65 and failed to conduct weekly skin and/or pressure ulcer assessments. Resident #65 developed five (5) more pressure ulcers, a Stage I (one) to the left heel on 06/23/2021, a DTI to the right heel on 06/26/2021, an unstageable pressure ulcer to the back of the left, lower leg on 08/12/2021, and two (2) Stage II (2) pressure ulcers to the left hip on 08/26/2021. Further, a wound care specialist assessed Resident #65's sacral pressure ulcer, on 08/26/2021, at 9:00 AM, and documented the wound had worsened. An acceptable allegation of compliance was	{F 000}		

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{F 000}	Continued From page 7 received on 09/02/2021 and the facility alleged removal of the Immediate Jeopardy effective 09/02/2021. A partial extended survey was initiated on 08/25/2021 and completed on 09/10/2021, and determined that the Immediate Jeopardy was not removed prior to exit on 09/10/2021. Immediate Jeopardy was also identified on 09/10/2021 at 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835 and F837) and 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The Immediate Jeopardy is ongoing. Based on the findings of the partial extended survey, concluded on 09/10/2021, it was determined the facility failed to utilize their resources to effectively manage the facility in order to maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Facility Administration and the Governing Body failed to ensure Quality Assurance/Performance Improvement activity was implemented and failed to provide oversight to ensure systems were in place to ensure the health and safety of residents in the facility. The facility's AOC stated the facility would complete "wound assessments" on 08/26/2021 and weekly wound assessments would be audited daily to ensure they had been completed. Review of Resident #14 and Resident #45's medical record revealed no documented evidence the facility assessed their pressure ulcers on 08/26/2021, as required by the AOC. Further, there was no documented evidence the facility was conducting weekly wound/pressure ulcer assessments for residents with pressure ulcers as stated in the AOC. Subsequently, there were no wound assessments available for the facility to audit.	{F 000}		

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{F 000}	Continued From page 8 Further review of the facility's AOC revealed residents would be weighed monthly. However, as of 09/10/2021, ten (10) residents had not been weighed since 08/03/2021, and seven (7) residents who had not been weighed since 08/06/2021. Additional deficient practice was identified at F585, F609, F623, F641, F689, F695, and F842 at "D" level; F584, F804, F809 and F925 at an "E" level; F557, F802, F803, F806, and F812 at "F" level; and F657 and F697 at "G" level. After supervisory review, on 09/22/2021, Immediate Jeopardy was identified, on 09/22/2021, and determined to exist on 03/26/2021 at 42 CFR 483.75 Pharmacy Services (F755). The facility was notified of the Immediate Jeopardy on 09/22/2021. The facility failed to provide pharmaceutical services to meet the needs of Resident #321, Resident #326, Resident #351, Resident #9, and Resident #321. The facility failed to acquire and administer prescribed medications to meet the needs of Resident #326, Resident #351, Resident #9 and Resident #324. In addition, the facility admitted Resident #321 on 07/16/2021 with the diagnoses of Urosepsis and Invasive Bladder Cancer with Physician's Orders to receive an antibiotic to treat the Urosepsis. The pharmacy required the facility to "cost over-ride" the medication before it could be dispensed. However, the facility failed to address the cost over-ride and Resident #321 did not receive the physician ordered antibiotic. A second acceptable allegation of compliance	{F 000}		

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{F 000}	Continued From page 9 was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 09/26/2021. The State Survey Agency determined the Immediate Jeopardy was removed as alleged during a revisit conducted on 09/28-30/2021, which lowered the scope and severity to "D" 42 CFR 483.10 Resident Rights (F580), 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686), 42 CFR 483.35 Nursing Services (F725), and 42 CFR 483.45 Pharmacy Services (F755); and to "E" at 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.25 Quality of Care (F692), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867), and 42 CFR 483.80 Infection Control (F880), while the facility monitors the effectiveness of systemic changes and quality assurance activities.	{F 000}		
{F 557} SS=F	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed	{F 557}	Preparation and execution of this plan of correction does not constitute admission	11/16/21

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{F 557}	Continued From page 10 to protect residents' dignity for one hundred eight (108) out of one hundred nine (109) residents in the facility. Observation of the noon meal on 06/15/2021, revealed residents' meal trays were observed to have plastic silverware, styrofoam cups, and styrofoam bowls. In addition, observation of the breakfast trays on 06/16/2021, revealed residents were being served food in styrofoam bowls and styrofoam cups on their meal trays. The findings include: Review of the facility's policy titled," Resident Rights", dated June 2020, revealed each resident would be treated with consideration, respect, and full recognition of their dignity and individuality in care for their needs. The policy also stated the resident had a right to a dignified existence. Observation of the lunch meal service on 06/15/2021 at 1:14 PM, revealed residents' meals were being served with plastic silverware, styrofoam cups, and styrofoam bowls. Observation of the breakfast meal on 06/16/2021 at 8:30 AM, revealed residents' meal trays had styrofoam cups and styrofoam bowls on them. Group interview conducted with six (6) residents (Residents #3, #16, #38, #51, #92, and #96), on 06/16/2021 at 10:13 AM, revealed their lunch and supper trays had plastic silverware which made it hard to cut anything, especially meats. The residents also stated they had been receiving styrofoam cups and bowls which they did not like. Continued interview revealed they had received the plastic silverware, styrofoam cups and bowls for a few weeks.	{F 557}	or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law. F 557 Respect, Dignity/Right to have personal property. Criteria 1: Residents #3, #16, #38, #51 and #92 are provided regular silverware, glasses and dishes unless they have specific orders which contraindicate this, or repairs are underway for the dishwasher. Criteria 2: All residents had the potential to be affected by this cited deficiency. No other residents were noted to be using Styrofoam or plastic dishware. Criteria 3 a) The Dietary Manager/Dietary Consultant/designee completed an inventory of all regular silverware, glasses and dishes to determine availability and the need to place any orders. Orders for additional needed items were submitted and received and put into service on 11/3/21. b) Dietary staff have received in-service education by the Dietary Manager/Dietary Consultant as completed by 11/1//21 on protecting resident dignity with the use of regular silverware, glasses and dishware for all	

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{F 557}	Continued From page 11 Interview with Dietary Aide (DA) #1 on 06/16/2021 at 2:00 PM, revealed they had been using plastic silverware, styrofoam cups, and styrofoam bowls for a few weeks. The DA stated they had been out of bowls, cups, and silverware and had used styrofoam bowls and cups and plastic silverware. Interview with DA #2 on 06/16/2021 at 2:15 PM, revealed they had been using plastic silverware, styrofoam cups, and styrofoam bowls since he had worked there, two (2) weeks ago. The DA stated they had been out of bowls, cups, and silverware. Interview with the Dietary Manager (DM) on 06/16/2021 at 1:30 PM, revealed she had quit on 06/15/2021. The DM stated the facility was out of silverware, cups, and bowls. The DM stated she was aware this was a dignity issue with using disposable dishes and silverware. Further interview with the DM revealed she would order the needed supplies from the supply company but never got the supplies. The DM stated it was a budget issue. Interview conducted with the Registered Dietician (RD) on 06/18/2021 at 4:18 PM, revealed she was aware the facility was using plastic silverware, styrofoam cups and bowls. Continued interview with the RD revealed she was told there was enough silverware that they were just not using it. Per interview, she had informed the DM they must use regular silverware as it was a dignity issue. The RD stated the DM had told her the company would not provide the cups and bowls that were needed. Interview with the Administrator on 06/19/2021 at	{F 557}	residents unless they have specific orders which contraindicate this, or repairs are underway for the dishwasher, and the need to notify the Dietary Manager when the last available box of dishware is put into service, so that an order may be placed to maintain supply. Criteria 4: a) The Dietary Manager will Monitor available dishware supplies monthly to determine when additional supplies need to be Ordered. Audits will be monthly for 3 months. b) Residents will be asked in each resident council meeting if they are being served their meals utilizing regular dishware. The Activity Director/Designee will notify the Dietary Manager for follow up of any residents who report they are not being served meals on regular dishware. Audits will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance. Criteria 5: Date of compliance: 11/16/2021	

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{F 557}	Continued From page 12 1:30 PM, revealed she had only been at the facility for two (2) weeks. She stated she had talked with the DM and the RD and they had not told her about using styrofoam cups and bowls and plastic silverware. The Administrator stated there was no problem with ordering replacement cups and bowls.	{F 557}		
{F 580} SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	{F 580}		12/30/21

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{F 580}	Continued From page 13 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy, it was determined the facility failed to notify the physician for nine (9) of fifty-seven (57) sampled residents when the resident	{F 580}	F 580 Notify of Changes (Injury/Decline/Room, etc.) Criteria 1: a) Resident #321 was	

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{F 580}	Continued From page 14 experienced a significant change in status and a need to alter treatment (Resident #321, Resident #323, Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, and Resident #81). On the morning of 07/18/2021, before breakfast, staff obtained Resident #321's blood glucose level, which was 67 mg/dL (milligrams per deciliter) (normal range 70 mg/dL to 110 mg/dL). However, there was no evidence the staff notified the resident's physician of the resident's low glucose levels. Later that afternoon, sometime after 3:00 PM, staff found Resident #1 unresponsive with a blood glucose level of 40 mg/dL. Interviews with staff revealed they administered Resident #321 both injectable and oral glucose, and the resident regained consciousness. However, there was no documentation made in the resident's medical record regarding the resident's second episode of hypoglycemia, or that staff notified the resident's physician. On 07/19/2021, at approximately 12:30 AM staff found Resident #321 unresponsive and clammy. Interviews and record review revealed the resident's blood glucose was 32 mg/dL. Staff again administered the resident injectable glucagon and oral glucose. The facility transferred Resident #321 to the hospital, where the resident was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. The hospital admitted Resident #321 to the Intensive Care Unit (ICU). Further, the facility admitted Resident #323 on 07/06/2021 after being on a ventilator at the hospital. At approximately 7:30 AM on 7/20/2021, a nurse aide entered the resident's room and discovered the resident was sweaty, clammy, and	{F 580}	discharged from this facility on 7-19-2021. b) Resident #323 was discharged from this facility on 7-20-2021. c) Resident #82 was discharged from facility on 8-9-2021 d) Resident #327 was discharged from facility on 8-15-2021 e) Resident #332 was discharged from facility on 9-1-2021 d) Residents #90, #330, #39,and #81 were weighed on 9-17-2021. The registered dietician completed a comprehensive nutrition assessment for the residents by 9-17-2021. The Director of Nursing or designee reviewed the comprehensive assessment recommendations, spoke with the attending MD and validated the diet orders, and recommendations were entered into PCC and matched the Dining RD tray card. The registered dietician and Director of Nursing reviewed diet orders in PCC to ensure they matched the orders in Dining RD. Criteria 2: a) All residents were assessed with diagnosis including:COPD, Asthma, or current pneumonia were by licensed nurses and/or respiratory therapist to ensure they were in no respiratory distress. No concerns were identified as completed 8-12-2021. On 8/14/2021 all residents with diagnosis of diabetes was assessed for s/s of hyper/hypoglycemia. None were present. b) All residents with orders for glucose monitoring were reviewed by the Regional Nurse and orders amended to include mandatory entry of glucose	

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{F 580}	Continued From page 15 having difficulty breathing. However, there was no evidence that staff notified the resident's physician of the resident's status, until the resident's family came to visit and insisted the facility transfer the resident to the hospital. Resident #323 was admitted to the hospital and diagnosed with acute hypoxic respiratory insufficiency, and left lower lobe pneumonia versus Atelectasis (lung collapse). In addition, the facility failed to ensure Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, and Resident #81's physicians were notified when the residents sustained significant weight loss. The facility's failure to ensure residents received treatment and care in accordance with professional standards of practice, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655), (F656), 42 CFR 483.25 Quality of Care (F684) (F686), (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR	{F 580}	value on the MAR vs. a check for completion. c) The DON and Registered Dietician reviewed weights for all residents to identify any that had demonstrated significant weight changes. For any residents demonstrating significant weight changes, the registered dietician completed a comprehensive nutrition assessment by 9-20-2021. The DON or designee and RD validated the diet orders, and recommendations were entered into PCC and matched the Dining RD tray card. The registered dietician and Director of Nursing reviewed diet orders in PCC to ensure they matched the orders in Dining RD.On 9-19-2021 Regional Nurse reviewed SBARs to identify residents who had a change in condition not related to weights, glucose levels or respiratory concerns. Criteria 3: a) The Respiratory Therapist and/or designee educated Licensed nurses on notification of MD with respiratory decline or distress beginning 8-12-2021. b) The DON/Designee educated all licensed nurses on identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting resident change in condition, documentation of blood sugar in the medical record, notification of physician and following physician orders beginning on 08-12-2021.Beginning on 8-12-2021 Don or Designee educated licensed staff on acute condition changes clinical protocol.	

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{F 580}	Continued From page 16 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing. A second acceptable allegation of compliance was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 09/26/2021. The State Survey Agency determined the Immediate Jeopardy was removed as alleged during a revisit conducted on 09/28-30/2021, which lowered the scope and severity to "D" 42 CFR 483.10 Resident Rights (F580), 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686), 42 CFR 483.35 Nursing Services (F725), and 42 CFR 483.45 Pharmacy Services (F755); and to "E" at 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.25 Quality of Care (F692), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867), and 42 CFR 483.80 Infection Control (F880), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled, "Acute Condition Changes-Clinical Protocol", dated March 2018, revealed prior to contacting the physician about an acute change in condition, the nursing staff would collect pertinent details to report to the physician, such as the history of present illness and previous and recent test results for comparison. Further review, revealed	{F 580}	c) Residents who are weighed weekly are weighed every Monday by CNAs. -CNAs report weights to the nurse who reviews and enters the weight into PCC -Any 5lb weight change or more will be verified by obtaining a re-weight by the next day. -Once the weight is verified, any significant change and/or 5lb weight loss or gain will be reported by the nurse to the MD and RD for recommendations/orders. -New orders will be reflected on the care plan, with the resident and or RP notified. d) Monthly weights are obtained in the same manner the first week of each month. e) All weights are reviewed in the weekly weight meeting by the IDT which consists of: Registered Dietician, Director of Nursing, MDS, Social Services, Activities, Dietary, Therapy and Clinical Staff Representative. The DON is responsible for running this meeting/process. Daily weights are reviewed by licensed staff and reported to the MD if significant weight changes noted by the nurse. f) All nursing staff were educated by 9-20-21 by the Director of Nursing, MDS coordinator or designee on proper weighing techniques, obtaining, documenting, and reporting of weight changes to the Registered Dietician. Beginning 11/24/2021 All agency staff and new hires will be educated on the process for notifying weight changes prior to working on the floor.	

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{F 580}	Continued From page 17 the nurse would assess, document, and report baseline information including; vital signs, neurological status, current pain level, level of consciousness, cognitive and emotional status, onset, duration and severity of illness, recent labs, history of psychiatric disturbances, mental illness or depression, all active diagnoses, and all current medications. The nurse would then contact the physician based on urgency of the situation, and for emergencies, they would call or page the physician and request a prompt response. Review of the facility's policy titled, "Management of Hypoglycemia", dated November 2020, revealed staff may need to make urgent notification to the physician if a diabetic resident had not eaten well or consumed sufficient fluids for two (2) or more days and had a fever, Hypotension, lethargy or confusion. For a resident who was lethargic, but not comatose, treatment might include oral glucose paste rubbed into buccal mucosa, intramuscular glucagon, or the administration of intravenous dextrose and immediate notification to the physician. 1. Review of Resident #321's medical record revealed the facility admitted the resident on 07/16/2021 with diagnoses that included Urosepsis, Diabetes Mellitus, and Invasive Bladder Cancer. Review of Resident #321's Minimum Data Set (MDS) assessment dated 07/19/2021 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of thirteen (13). The facility assessed the resident to be cognitively intact.	{F 580}	g) On 8-31-21 the Dietary Manager was educated by the Regional CDM on diet order accuracy and provision of timely nutritional assessment to ensure diet order accuracy, when the diet orders are put into PCC the nurse entering the order will send written communication to the dietary staff that will include diet and texture. Dietary Manager will enter the order into the tray care system. All diet orders from the previous day should be reviewed in clinical meeting to ensure accuracy and communication was completed. h) By 9-20-21 the Director of Nursing or Regional Director of Nursing educated nurses and Dining Director on the process for entering, activating, and/or implementing the registered dietician□s recommendations for dietary orders. i) Snacks are being offered daily morning and afternoon by the restorative or activity aides or designee to all residents. Criteria 4: a) During the Ad-hoc QAPI meeting on 08-12-2021 the above listed education and processes were reviewed, and audits put into place to ensure compliance with this process. DON/Designee completed audits of staff knowledge with verbal quizzing of identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, SBARS and MD notification. Staff were quizzed randomly across all shifts; beginning week of 8/15/2021 5 staff were quizzed weekly	

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{F 580}	Continued From page 18 Review of Resident #321's Baseline Care Plan dated 07/16/2021, revealed the care plan did not include the resident's diagnosis of Diabetes Mellitus. Review of Resident #321's Physician Orders Summary Report, revealed Physician's Orders dated 07/17/2021, which stated staff were to monitor for signs/symptoms of hypoglycemia/hyperglycemia (low/high blood sugar) every shift, obtain blood glucose levels as needed and to notify the physician if blood glucose was below 70 mg/dL or above 350 mg/dL. Review of Resident #321's Medication Administration Record (MAR) for June 2021, revealed the MAR had an entry stating diabetic monitoring every shift for hypoglycemia/hyperglycemia, may complete finger sticks as needed, and to notify the physician if blood glucose was below 70 mg/dL or above 350 mg/dL. Review of Nursing Notes dated 07/18/2021 at 3:20 PM, revealed at approximately 7:30 AM on 07/18/2021, Licensed Practical Nurse (LPN) #6 obtained a blood glucose reading for Resident #321, which was 67 mg/dL. The Note stated that after breakfast, LPN #6 obtained a follow-up blood glucose level, which she documented as 139 mg/dL. However, there was no indication or documentation that LPN #6 notified the resident's physician when the resident's blood glucose dropped below 70 mg/dL. In addition, there was no evidence the LPN continued to monitor the resident for signs/symptoms of hypoglycemia/hyperglycemia or re-checked the resident's blood glucose level.	{F 580}	x4 then monthly x 2. Audits will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance. b) Beginning 11/24/21 DON/Designee will monitor documented blood sugar results daily Monday thru Friday (Weekend will be reviewed Monday) or until compliance is met in morning clinical meeting and any blood sugar results outside of normal range will be reviewed for MD notification and implementation of any physician orders. Care Plan will be reviewed and updated as needed. Audits will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance c) Beginning 11/24/21 The DON/Designee will monitor respiratory assessments and SBAR communications for acute change in condition or change in respiratory status, any acute change condition or change in respiratory status will be reviewed for MD notification and implementation of any physician order. Care Plan will be reviewed and updated as needed. Audits will be weekly x 4 then monthly x 2. Audits will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance d) Beginning 11/24/2021 New interventions will be care planned in the morning meeting by the DON, ADON or nursing designee. Audits will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance. e) Starting 11/24/2021	

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{F 580}	Continued From page 19 Interview with Resident #321's Daughter on 08/02/2021 at 5:30 PM, revealed she visited the resident on 07/18/2021 and arrived to the facility at 10:45 AM for a scheduled visit. She stated Resident #321 told her his/her blood sugar had dropped to 67 mg/dL that morning. However, the daughter stated no staff re-checked the resident's blood glucose level or assessed the resident for signs/symptoms of hypoglycemia/hyperglycemia while she was at the facility from 10:45 AM until approximately 3:00 PM. Interview with Resident #321's Spouse on 07/28/2021 at 2:19 PM, revealed he/she talked with Resident #321 on the phone numerous times on 07/18/2021, and the resident reported feeling like his/her blood glucose was low. However, the resident told the spouse at 4:00 PM, that staff had not re-checked his/her blood sugar since early that morning when his/her blood glucose was low. Interview with LPN #6 on 07/27/2021 at 4:10 PM, revealed on the morning of 07/18/2021, she obtained a blood glucose of 67 mg/dL for Resident #321. She stated she re-checked the resident's glucose after the breakfast meal and it was back up to 139 mg/dL. LPN #6 stated she could not recall if she notified the physician that the resident's blood glucose had dropped below 70 mg/dL. However, the LPN stated that since the resident's blood glucose came up to 139 mg/dL, she probably thought the resident was doing well, and she did not need to notify the physician that the resident's blood glucose had dropped below 70 mg/dL. Interview with SRNA #1 on 07/27/2021 at 4:40 PM, revealed she was working on 07/18/2021	{F 580}	snack intake will be audited by Dietary Manager daily for 1 week; weekly for 3 weeks; monthly thereafter for 2 months then quarterly until in substantial compliance. Audits will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance. f) All weights are reviewed in the weekly Wednesday at-risk meeting to ensure all notifications and care plans are updated by the IDT which consists of: Registered Dietician, Director of Nursing, MDS, Social Services, Activities, Dietary, Therapy and Clinical Staff Representative. The DON is responsible for running this meeting/process. g) Beginning 11/24/2021 the DON or designee will audit weekly weights weekly x 4 weeks then monthly x 2 months to ensure no significant weight changes. If weight changes are present then MD, RP and RD will be notified. Criteria 5; Date of Compliance 12/30/2021	

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{F 580}	Continued From page 20 during day shift from 6:00 AM to 6:00 PM. She stated she did recall Resident #321 having a blood sugar of 67 mg/dL that morning. Additional interview with SRNA #1 on 08/03/2021 at 3:19 PM, revealed later that same day, she entered Resident #321's room late in the afternoon, exact time unknown, and found the resident non-responsive and immediately alerted LPN #6. She stated LPN #6 got RN #1 from the other end of the unit to help her, and both nurses were working with the resident. Interview with LPN #6 on 07/30/2021 at 11:30 AM revealed that Resident #321 had a hypoglycemic episode during the late afternoon on 07/18/2021, but could not recall the exact time, however, stated it was after lunch. She stated when she entered the room the resident was not responsive and she obtained a blood sugar of around 40 mg/dL. She stated she got RN #1 from the other end of the unit to assist her and administered an injection of Glucagon to the resident as well as oral glucose and the resident began to respond. LPN #6 stated following the episode she thought the resident's blood glucose had come up to "around 139 mg/dL", but she was unsure. LPN #6 stated she notified the resident's physician of the hypoglycemic event. However, review of Resident #321's medical record revealed no documentation of the incident, no documentation of the resident's blood glucose levels, and no documentation that LPN #6 notified the physician of the event. Interview with Registered Nurse (RN) #1 on 07/30/2021 at 10:54 AM revealed she was working on 07/18/2021 on day shift from 7:00 AM to 7:00 PM, and recalled late in the afternoon LPN #6 came to her requesting assistance with	{F 580}		

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{F 580}	Continued From page 21 Resident #321, who had a blood glucose level of 40 mg/dL. RN #1 stated when she arrived to the room the resident was non-responsive. RN #1 stated they administered the resident a Glucagon injection, and the resident began to regain consciousness. However, according to RN #1, the resident's blood sugar remained low, and LPN #6 administered the resident oral glucose. RN #1 stated after administering the oral glucose, Resident #321's blood glucose came up to 111 mg/dL. RN #1 stated she then returned to her end of the unit, and did not know if LPN #6 contacted the physician regarding the hypoglycemic event and the resident's low blood glucose level. Review of Resident #321's Nursing Notes revealed an entry dated 07/19/2021 at 12:23 AM, stating staff had found the resident unresponsive with a blood glucose of 32 mg/dL. The note stated staff administered the resident two Glucagon injections and oral glucose. However, Resident #321 remained un-responsive and experienced labored breathing. Staff notified the resident's physician and received orders to send the resident to the hospital. Continued review of the nursing notes revealed Emergency Medical Services arrived to the facility at 1:00 AM and transferred the resident to the hospital Emergency Department (ED). Review of hospital records for Resident #321 dated 07/19/2021 and interview with the ED Physician on 08/03/2021 at 8:22 PM, revealed when Resident #321 arrived to the ED on 07/19/2021, the resident was unresponsive and required intubation. Continued review of the record and interview with the physician revealed Resident #321 was in acute respiratory failure and was hypoxic due to prolonged hypoglycemia.	{F 580}		

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{F 580}	Continued From page 22 Interview with Physician #1, Resident #321's physician, on 08/04/2021 at 1:05 PM revealed he did not recall staff notifying him of Resident #321's hypoxic event on 07/18/2021 before breakfast or the hypoxic event that afternoon, when staff found the resident unresponsive. Physician #1 stated if staff had notified him on the morning of 07/18/2021, when Resident #321 had a blood glucose of 67 mg/dL, he would have sent the resident to the hospital for evaluation. Physician #1 also stated the only time he remembered staff notifying him about Resident #321 was during the early morning hours of 07/19/2021, when staff found Resident #321 nonresponsive. Interview with the Director of Nursing (DON) on 08/11/2021 at 12:05 PM revealed that she expected nursing staff to notify the physician if a resident had a change in condition and complete a nursing assessment on the resident. The DON stated she was not aware that Resident #321 had two hypoglycemic episodes without physician notification occurring prior to the resident going to the hospital on 07/19/2021. Continued interview with the DON revealed she did not conduct routine monitoring or have any system in place to ensure physician notification was occurring timely and as warranted. Interview with the Administrator on 08/10/2021 at 1:50 PM, revealed she expected nursing staff to conduct a nursing assessment anytime a resident had a change in condition and notify the physician and the family. The Administrator stated she was unaware Resident #321 had two previous episodes of hypoglycemia.. However, she stated staff should have called the physician.	{F 580}		

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{F 580}	Continued From page 23 2). Review of Resident #323's medical record revealed the facility admitted the resident on 07/06/2021, with diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Autistic Disorder, Sepsis, Diabetes Mellitus, Dysphagia, Pneumonia and Aphasia. Review of Resident #323's Minimum Data Set (MDS) Admission assessment dated 07/13/2021, revealed the facility assessed the resident to have severely impaired cognition. Interviews on 07/28/2021, at 11:43 AM, with State Registered Nurse Aide (SRNA) #14, and at 2:35 PM with SRNA #15, revealed on the morning of 07/20/2021 at approximately 7:15 AM, they observed Resident #323 to be sweaty, clammy, red faced, and having difficulty breathing, which they stated was not normal for the resident. SRNA #14 stated she notified RN #6 of the resident's change in condition, and the nurse administered the resident a breathing treatment, but the resident continued to have difficulty breathing. SRNA #14 stated the resident was "breathing pretty hard". SRNA #15 stated RN #6 administered the resident another breathing treatment "a couple hours later". However, the SRNAs stated Resident #323 continued to have difficulty breathing. Continued interview revealed the resident's family arrived at the facility at approximately 11:15 AM and insisted the facility send the resident to the ED. Interview with RN #6 on 07/28/2021 at 3:45 PM, revealed on 07/20/2021 at approximately 7:15 AM, staff notified her that Resident #323 was "congested". She stated she was not the assigned nurse to Resident #323. However, she went to the room to check on the resident. She	{F 580}		

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{F 580}	Continued From page 24 stated when she entered the resident's room, the resident had audible wheezing and was using accessory muscles to aide in breathing. RN #6 stated she had last seen Resident #323 at approximately 6:15 AM, and the resident was not having difficulty breathing at that time, and the respiratory distress was new for the resident. However, RN #6 stated that she did not notify the resident's physician to report the resident's change in condition, because LPN #3 was the resident's assigned nurse. RN #6 stated it was LPN#3's responsibility to call the physician. Continued interview with RN #6 on 07/28/2021 at 3:45 PM, and review of Resident #6's Treatment Administration Record (TAR) revealed she administered a breathing treatment to Resident #323 at 7:43 AM, which provided the resident with some improvement in breathing. However, according to RN #6, the improvement did not last long and the resident's status declined. RN #6 stated she administered the resident another breathing treatment at 11:34 AM, and assumed that LPN #3 would notify the physician of the resident's condition. Interview with LPN #3 revealed she was the nurse assigned to Resident #323 on 07/20/2021. She stated that at approximately 6:30 AM on 07/20/2021, Resident #323 "seemed ok". However, at approximately 7:30 AM she realized "something was going on" with the resident. She stated she assessed the resident to be breathing fast and using accessory muscles to aide in breathing. LPN #3 stated she notified Physician #1 around 8:15 AM and received a new order for a chest x-ray. However, there was no documented evidence in the resident's medical record to indicate that LPN #3 notified the	{F 580}		

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{F 580}	Continued From page 25 physician. She stated that following the breathing treatments administered by RN #6, Resident #323 condition "stayed about the same". Continued interview with LPN #3 revealed that the resident's family came in around 11:00 AM, and immediately requested the resident go to the ED. LPN #3 stated she called Physician #1, and received an order to transfer the resident to the hospital. Interview with Resident #323 family member on 08/02/2021 at 8:50 AM revealed she arrived to the facility on 07/20/2021 at approximately 11:00 AM. She revealed that upon arriving to the unit, he/she could hear the resident breathing from the hallway. The family member stated that she requested the resident go to the hospital for evaluation. Further review of the medical record for 07/20/2021, revealed no documented evidence the facility staff notified the resident's physician until after the resident's family member arrived to the facility. Review of the record revealed a change of condition form completed at 12:12 PM, which stated the resident was having shortness of air, abnormal lung sounds, labor or rapid breathing and cough. Continued review revealed documentation that the facility notified Physician #1 at 11:45 AM, and obtained an order to send Resident #323 to the ED for evaluation. Interview with Physician #1 on 08/04/2021 at 1:00 PM revealed he did not recall the facility notifying him of a change in Resident #323 on 07/20/2021. Physician #1 stated if the facility had called him, a chest x-ray would not have been standard of care for a resident exhibiting stridor (high pitched sound from breathing indicating a restriction) and	{F 580}		

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{F 580}	Continued From page 26 difficulty breathing. The physician stated he would have initiated increased monitoring of vital signs and instructed the staff to monitor for signs/symptoms of decompensation of respiratory status, or more likely sent the resident to the ED for evaluation, especially if the resident was exhibiting stridor. Continued interview with Physician #1 revealed he expected staff to notify him with changes of condition. Review of Resident #323's ED record revealed the ED staff assessed the resident to have audible stridor, increased respiratory effort, was using accessory muscles to breathe and had mild wheezing to bilateral lungs. Continued review of Resident #323's hospital record revealed the resident was admitted to the ICU (Intensive Care Unit) at 10:54 PM. The hospital admitted Resident #323 with diagnoses of Acute Hypoxic Respiratory Insufficiency, Left Lower Lobe Pneumonia versus Atelectasis (collapsed lung), and an elevated Lactate level (results from low flow of oxygen level). Interview with the Administrator on 08/10/2021 at 1:48 PM and the Interim Director of Nursing on 08/11/2021 at 12:05 PM, revealed they expected staff to notify the resident's physician immediately when a change of condition such as difficulty breathing occurred. In addition, the Interim Director of Nursing and Administrator stated the facility had no system in place to monitor residents' records to ensure staff notified the physician when a resident's condition warranted or that notification was being made timely and appropriately. 3. Review of Resident #90's medical record revealed the facility admitted the resident on 10/07/2016 with diagnoses that included	{F 580}		

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{F 580}	Continued From page 27 Dementia, Unspecified Protein-Calorie Malnutrition and Dysphagia. Review of Resident #90's Minimum Data Set (MDS) assessment dated 02/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eight (8) which indicated the resident had moderate cognitive impairment. The assessment stated the resident weighed 97 pounds. Review of Resident #90's comprehensive care plan in place on 02/19/2021, revealed the facility identified the resident had a potential for weight concerns and was at risk for malnutrition due to dependence on staff for eating, diagnosis of Dysphagia and Vitamin B12 deficiency. Review of Resident #90's weight record revealed on 03/06/2021, the resident weighed 86.8 pounds. This weight reflected a loss of 10.5% in fifteen days. However, there was no evidence the physician was notified of the resident's weight loss. Review of the Registered Dietitian's (RD) documentation dated 04/09/2021, revealed the RD noted Resident #90 had sustained a 8.8% weight loss in 30 days, and 10.5 % in 180 days. Continued review of Resident #90's weight record revealed on 06/08/2021, the resident's weight was 84.7 pounds, and on 06/15/2021, the resident's weight was 82.5 pounds. Review of the RD's documentation on 06/16/2021, revealed the RD noted an 11.9 % weight loss in 30 days, a 12.9 % weight loss in 90 days, and an 11.5 % weight loss in 180 days.	{F 580}		

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{F 580}	Continued From page 28 Further review of Resident #90's weight record revealed on 06/29/2021, the resident weighed 82.3 pounds. Review of RD documentation dated 07/07/2021, revealed the RD documented the resident had lost 13.1 % in 90 days and 11.7% loss in 180 days. Further review of Resident #90's weight record revealed on 07/08/2021, the resident's weight was 80.2 pounds. Observation of staff weighing Resident #90 on 08/05/2021, revealed the resident weighed 81.1 pounds. However, review of Resident #90's medical record from 02/19/2021 thru 08/05/2021, revealed no evidence the facility notified the physician of Resident #90's 17% weight loss in approximately 167 days. 4. Review of Resident #327's medical record revealed the facility admitted the resident on 03/15/2021 with diagnoses that included Dementia, Anemia, and Hyperlipidemia. Review of Resident #327's MDS admission assessment dated 03/22/2021 revealed the facility assessed the resident to be severely cognitively impaired. The assessment also stated the resident complained of difficulty or pain with swallowing. The facility assessed the resident to be independent with meals requiring set up help only, and weighed 205 pounds. Review of Resident #327's baseline care plan did not contain information concerning Resident #327's nutritional status.	{F 580}		

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{F 580}	Continued From page 29 Review of a RD evaluation dated 03/26/2021, revealed Resident #327 weighed 194.2 pounds, and the RD documented the resident had sustained a 5% weight loss in one week. Review of the RD's documentation dated 04/09/2021, revealed on 04/06/2021, Resident #327 weighed 184.2 pounds, a significant weight loss of 10% in 30 days. Further review of the report revealed the RD recommended referring the resident to the physician for a medication review due to the facility's documentation that the resident's intake was "fair", but continued to experience weight loss. However, there was no evidence the facility contacted the resident's physician. Review of the RD's documentation dated 05/07/2021, revealed she evaluated Resident #327 on 05/07/2021, because the resident weighed 182.5 pounds on 04/27/2021. The RD documented the resident had lost 6% of his/her body weight in the past 30 days and 10.8 % of body weight in the past 90 days. Review of the RD's documentation revealed on 06/06/2021, the RD evaluated Resident #327 because the resident weighed 178.5 pounds on 06/01/2021, a significant weight loss of 11.4% in 90 days. Continued review of Resident #327's record revealed the resident weighed 170 pounds on 08/03/2021, which was a 5.5 percent weight loss in 30 days. Observation of staff weighing Resident #327 on 08/05/2021, revealed the resident weighed 170.3 pounds.	{F 580}		

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{F 580}	Continued From page 30 However, review of Resident #327's medical record from 03/22/2021 thru 08/05/2021, revealed no evidence the facility notified the physician of Resident #327's 17% weight loss in approximately 136 days. 5. Review of Resident #82's medical record revealed the facility admitted the resident on 05/12/2021 with diagnoses including Parkinson's Disease, Alzheimer's Disease, Insomnia and Vitamin D Deficiency. Further review of Resident #82's admission data revealed the resident's weight was 153.6 pounds on 05/12/2021. Review of Resident #82's MDS admission assessment dated 05/18/2021, revealed the resident was severely cognitively impaired, but was independent with eating, requiring set up only. The assessment also stated the resident's weight was 148 pounds, a 5.6 pound weight loss in one week. Review of Resident #82's weight record revealed on 06/01/2021, the resident weighed 145.1 pounds, a 5.5 % weight loss in less than 30 days. Review of the RD assessment dated 06/05/2021, identified Resident #82 had sustained a 5.5 % weight loss in 30 days, and a 13.4 % loss in 90 days. Continued review of Resident #82's weight record revealed on 06/08/2021, the resident weighed 143.2 pounds. Further review of Resident #82's record revealed the resident weighed 139.1 pounds on	{F 580}		

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{F 580}	Continued From page 31 07/20/2021, 137.3 pounds on 07/27/2021 and 132.9 pounds on 08/03/3021, a significant weight loss of 13.4% in the last 90 days. However, review of Resident #82's medical record from 05/12/2021 thru 08/05/2021, revealed no evidence the facility notified the physician of Resident #82's 13.4 % weight loss in approximately 85 days. 6. Review of Resident #330's medical record revealed the facility admitted the resident on 03/11/2020 with diagnoses that included Cerebral Infarction, Diabetes Mellitus, Hemiplegia and Aphasia. Review of Resident #330's MDS dated 05/12/2021, revealed the facility assessed the resident to have a BIMS score of four (4), indicating the resident was cognitively impaired. Further review revealed the facility assessed the resident to have swallowing difficulties and held residual food in his/her mouth. Further review of the assessment revealed the facility assessed the resident to require the limited assistance of one (1) staff member at meals. The assessment stated the resident's weight was 239 pounds. Review of Resident #330's care plan in place on 05/12/2021, revealed the resident was at risk for potential weight concerns/malnutrition because of the resident's diagnosis of Dysphagia. However, the facility identified the resident was above ideal body weight and was obese. Interventions initiated on the care plan included notifying the physician of significant weight loss. Review of Resident #330's weight record revealed on 06/08/2021, the resident's weight	{F 580}		

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{F 580}	Continued From page 32 was 213.6 pounds. Review of a RD assessment dated 06/28/2021, revealed the RD documented the resident had lost 10.6% of his/her body weight in 180 days. Review of Resident #330's weight on 08/03/2021, revealed the resident weighed 210 pounds. Observation of Resident #330's weight on 08/05/2021, revealed the resident weighed 210 pounds. However, review of Resident #330's medical record from 05/12/2021 thru 08/05/2021, revealed no evidence the facility notified the physician of the resident's 12% weight loss in approximately 85 days. 7. Review of Resident #39's medical record revealed the facility re-admitted the resident on 04/03/2018 with diagnoses that included Diabetes Mellitus, GERD, and Chronic Diastolic Heart Failure. Review of Resident #39's MDS assessment dated 03/01/2021 revealed the facility assessed the resident to have a BIMS' score of 15, indicating the resident was cognitively intact. The assessment also revealed the resident was independent with eating and weighed 296 pounds. Review of Resident #39's weight record revealed the resident weighed 290 pounds on 04/04/2021 and 253.3 pounds on 06/22/2021. However, review of Resident #39's medical record from 03/01/2021 thru 06/22/2021, revealed no evidence the facility notified the physician of the resident's 14.4% weight loss in approximately	{F 580}		

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{F 580}	Continued From page 33 113 days. 8. Review of Resident #332's medical record revealed the facility admitted the resident on 03/12/2021 with diagnoses that included Diabetes, Chronic Kidney Disease, Gastro-Esophageal Reflux Disease, Hypertension, Atrial Fibrillation, and Femoral Neck Fracture. Review of Resident #332's Dietary-Nutrition Data Collection assessment completed on 03/16/2021 at 5:39 PM, revealed the resident's weight was 199.9 pounds and the resident's intake was inadequate to meet the resident's needs. Review of Resident #332's MDS assessment dated 03/19/2021, revealed the facility assessed the resident to have a BIMS' score of 14 indicating intact cognition. Further review of the assessment revealed the resident was independent with eating, and weighed 200 pounds. Review of Resident #332's weight record revealed the resident weighed 182.6 pounds on 04/05/2021. Review of the Nutrition Progress Note by the RD, dated 04/11/2021, revealed Resident #332 had sustained a 9% weight loss in thirty days. Review of Resident #332's weight record revealed the resident weighed 184.9 pounds on 05/04/2021. Review of a Nutrition Progress Note for Resident #332 dated 05/27/2021, revealed the resident had a 7.6% weight loss in 90 days. Further review of Resident #332's weight record revealed the resident weighed 183.6 pounds on	{F 580}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 580}	Continued From page 34 06/07/2021, 182.9 pounds on 07/05/2021 and 179.9 pounds on 08/03/2021. However, review of Resident #39's medical record from 03/19/2021 thru 08/05/2021, revealed no evidence the facility notified the physician of the resident's 10% weight loss in approximately 140 days. 9. Review of Resident #81's medical record revealed the facility re-admitted the resident on 09/30/2019 with Dementia, Anemia, Anxiety and Major Depressive Disorder. Review of Resident #81's MDS assessment dated 05/18/2021, revealed the resident weighed 117 pounds. Review of Resident #81's weight record revealed on 06/01/2021, the resident weighed 109.2 pounds. Review of a RD assessment for Resident #81, completed on 06/05/2021 revealed the resident sustained a 6.5% weight loss in 30 days and 8.9% weight loss in 90 days. Review of the RD's documentation for Resident #81 dated 07/07/2021, revealed on 07/06/2021, the resident's weight was 108.7 pounds, representing a 9.4% weight loss in 90 days. Review of Resident #81's weight on 08/03/2021, revealed the resident weighed 107.1 pounds. However, review of Resident #81's medical record from 03/19/2021 thru 08/05/2021, revealed no evidence the facility notified the physician of the resident's 8.4 % weight loss in approximately 80 days.	{F 580}		

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{F 580}	Continued From page 35 Interview with Physician #1 on 08/04/2021 at 1:00 PM and on 08/27/2021 at 1:18 PM revealed he could recall being notified by staff at times related to residents that had lost weight; however, he was unable to recall specific dates or residents. He stated he expected the facility to follow its policy to weigh residents monthly and notify him of weight loss. Physician #1 stated he usually initiated Periactin (a medication used as an appetite stimulant) when a resident was not eating and losing weight. He also stated he expected staff to follow their policies related to physician notification in the facility. Interview with the Assistant Director of Nursing/Interim Director of Nursing (ADON/IDON), on 08/18/2021 at 9:50 PM, revealed she had been the ADON at the facility for approximately one (1) year, and was placed in the IDON position a few weeks ago. The ADON/IDON stated she had never monitored residents' weights, and never monitored to ensure the physician was notified when residents lost weight in the facility. Interview with the Administrator, on 08/11/2021 at 6:00 PM and on 08/18/2021 at 3:30 PM, revealed she had been the facility's Administrator since 06/07/2021. The Administrator stated the facility had no systems in place to monitor residents' weight loss or nutritional needs. She stated she was not monitoring to ensure the residents' physician was notified when residents experienced weight loss. She stated she was not aware the physician had not been notified of residents' weight loss, but stated he should have been. **The facility alleged the following was	{F 580}		

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{F 580}	Continued From page 36 implemented to remove Immediate Jeopardy effective 09/26/2021: 1). Braden Scale Assessments were completed on all residents by facility nurses on 08/28/2021 and comprehensive full body skin assessments were completed on all residents on 09/11/2021. The facility utilized the Braden Scale Assessment and comprehensive full body skin assessment to review and update care plans of residents who had pressure injuries by 09/17/2021. 2). The wound care physician evaluated Resident #65 on 08/25/2021. Staff assessed and measured all pressure injuries, and staff evaluated all current treatments and reported them to the Medical Director/Physician #1 by 09/17/2021. 3). Beginning 09/17/2021, upon admission a skin assessment and Braden Scale assessment will be completed, and the baseline care plan will be developed within 48 hours to include any pressure ulcer or potential for pressure ulcer. A comprehensive care plan will be developed within 21 days of admission to include pressure ulcers or potential pressure ulcers and include interventions to prevent pressure ulcer development or worsening of pressure ulcers. 4). Residents #45, #65, #308, #309, #311, #314 and #320 were bathed including a shower, nail care and moisturizing lotion applied post shower, and assisted with dressing in clean appropriate clothing. Clean linens were placed on the residents' beds on 09/11/2021. The residents were evaluated by social services on 09/15/2021. 5). All residents were offered a shower and	{F 580}		

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{F 580}	Continued From page 37 interviewed to obtain shower/hygiene preferences by the Director of Nursing (DON) or designee. New bath/shower schedules were implemented by nursing staff to accommodate resident preference. Resident preferences for hygiene were obtained and incorporated into resident care plans and State Registered Nurse Aide (SRNA) care plans by the Regional Nurse Consultant were completed on 09/13/2021. 6). On 08/28/2021, the Registered Dietitian (RD) began reviewing all residents' diets and made recommendations for meal changes or supplements to promote healing and to address any weight loss issues. 7). All residents with the diagnoses of Diabetes and Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by licensed nurse and/or Respiratory Therapist with no concerns were identified completed 08/13/2021. 8). The Regional Nurse reviewed all residents with orders for glucose monitoring by 07/30/2021 and orders were amended to include mandatory entry of glucose values on the Medication Administration Record (MAR). 9). The Regional Certified Dietary Manager (CDM) observed the meal service for breakfast, lunch and dinner on 09/11/2021, all three meals were delivered on time. 10). Direct Care staffing was increased through recruitment efforts with additional staffing provided through agency and travel contracts. Direct care nursing staff schedules for the next day will be reviewed daily by the Director of	{F 580}		

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{F 580}	Continued From page 38 Nursing and the Administrator to ensure staffing levels are adequate to meet the acuity of the residents. The staff will be validated as present on the unit at the start of each shift by the Director of Nursing, Nursing Supervisor, Administrator or designee. Direct care nursing staff call offs will be replaced by calling other qualified staff to see if they can fill the opening, and/or calling agencies to see if they have qualified staff to fill the opening. If direct care staff cannot be replaced the Director of Nursing, Assistant Director of Nursing, or member of the nursing management team will fill the shift. If appropriate staffing levels cannot be met, the center will prioritize resident care that can be achieved during emergency staffing, prioritize required task including administration of medication, no showers- sponge baths, care provided to incontinent residents, turn residents that cannot turn self, meals served timely, and assist residents with meal if needed. 11). The facility has increased dietary staffing through recruitment efforts and appropriate staffing levels have been achieved to ensure meals are prepared and delivered timely. 12). On 08/11/2021, all residents including #64, #86 and #322, were reassessed for psychosocial and physical forms of abuse with Brief Interview for Mental Status (BIMS) score of eight (8) or above and skin integrity reviews for residents with BIMS less than eight (8) were completed by Licensed Nurse. Residents with a diagnosis of Dementia had their Care Plan reviewed and revised, as necessary by the Minimum Data Set (MDS) Coordinator on 09/07/2021. No new residents were identified as indicating any psychosocial and/or physical harm.	{F 580}		

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{F 580}	Continued From page 39 13). The Regional Nurse Consultant completed a wandering risk assessment on all residents by 08/16/2021. All residents who were identified as at risk for wandering had care plans reviewed and updated by the MDS Coordinator. A list of all identified active wander risk residents were placed at each nursing station with a list of potential interventions for nursing to reference. 14). Residents #39, #65, #81, #90, #330 and #332 were weighed by 09/17/2021. The Registered Dietician (RD) completed a comprehensive nutrition assessment and RD recommendations were reviewed for recommendations by the Director of Nursing (DON) or designee on 09/17/2021. Further, the DON or designee, spoke with the attending Medical Doctor (MD) and validated the diet orders and recommendations. Recommendations were entered into the electronic medical record and on the tray card. The Registered Dietician and Director of Nursing (DON), reviewed diet orders in electronic medical record to ensure both the record and tray card reflected accurate information on 09/17/2021. 15). Beginning 09/15/2021, staff began offering snacks to all residents daily in the morning and afternoon by the restorative nurse aide, activity aides, or designee. Snacks ordered by a physician will be documented by the restorative aide, dietary aides and/or licensed nursing staff. 16). The facility evaluated the COVID-19 unit on 08/11/2021, located on the 5th floor of the facility for compliance with CDC guidelines and implemented yellow and red zones. The DON identified two (2) residents who had been	{F 580}		

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{F 580}	Continued From page 40 exposed to positive residents and a yellow zone was designated with erection of a plastic zip wall barrier and those two (2) residents were moved to this zone on 08/11/2021. 17). The facility had three (3) residents who were in the red zone on 08/11/2021(Residents #327, #328 and #329). Residents #327, #328 and #329 have completed quarantine per facility policy and physician orders. Residents #311 and #314 completed quarantine per COVID-19 policy and physician's order. Residents #311 and #314 were no longer in isolation. 18). All staff eligible for testing were tested for COVID-19 on 09/16/2021. The facility did not identify any new cases based on the employee testing on 09/16/2021. All residents eligible were tested for COVID-19 on 09/17/2021. The facility did not identify any new positive cases. 19). The facility was conducting ongoing surveillance testing as recommended for COVID-19. Positive COVID-19 residents will be placed in isolation zone (red zone) and placed in droplet precautions with use of personal protective equipment. The facility will provide physician notification, family notification and care plan revisions. The DON or designee will review newly positive COVID-19 residents to ensure isolation precautions have been initiated. In addition, any resident exposed will be placed in droplet precaution in isolation zone (yellow). The facility will provide physician notification, family notification and care plan revisions. The facility employee testing protocol will be twice weekly on designated days effective 08/16/2021. The facility requires all staff must be tested on designated days. If the employee is not tested, the facility will	{F 580}		

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{F 580}	Continued From page 41 not allow the employee to work without a current negative COVID-19 test. During testing, the employee will be tested prior to entering the facility by the Infection Prevention Nurse or designee. All testing dates and times will be posted to the employee page, time clock and common areas. 20). The facility screens all residents once a shift for signs and/or symptoms of COVID-19 and documented on the Medication Administration Record (MAR). The facility implemented monitoring for signs and/or symptoms on all residents on 09/17/2021. 21). Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351, medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). The facility stated all residents will receive their medication as ordered beginning 09/23/2021 and implemented pharmacy and physician notification if any medication was unavailable. The facility will abide by new orders from the physician regarding the unavailable medication. 23). The facility formulated an agreement on 09/23/2021, with the facility's pharmacy to provide the facility with a three (3) day supply of medications that requires the facility's approval for cost authorization while pending cost review. 24). New admissions and re-admissions entering the facility after normal business hours and on weekends will have discharge orders submitted, entered into the electronic medical record and submitted to pharmacy through pharmacy	{F 580}		

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{F 580}	Continued From page 42 integration. The facility implemented the use of fax transmittal as a backup to the electronic pharmacy integration by entering the order in the electronic medical record to receive medications. If the facility does not receive medications in a timely manner the pharmacy will be notified, and the facility will utilize the emergency medication kit. If an emergency arises and medication is unavailable, the physician will be notified for substitution and/or new orders. 25). The Regional Nurse Consultant, Director of Nursing, and licensed nursing staff completed an audit of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. 26). The facility conducted a Quality Assurance Performance Improvement (QAPI) meeting on 08/12/2021. The facility reviewed education, facility process, and audited implementation to ensure compliance with the AOC and all audits. The Administrator oversees the QAPI committee. The QAPI committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 27). The facility appointed an Interim Administrator on 09/13/2021 to replace the current Administrator. The facility's Interim Administrator will receive daily oversight and guidance from the Regional Vice President or Regional Director of Operations and Regional Clinical Nurse for 30 days. Upon completion of the thirty-day oversight, the Regional Administrative Team will audit the Administrator to determine if continued daily oversight is needed.	{F 580}		

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{F 580}	Continued From page 43 The administration has direct oversight and responsibility to direct, discipline, and communicate areas of concern and process improvement. 28). The Administrator, Medical Director, and QAPI Committee reviewed procedures for a contact person for call-ins, answering call lights, Activities of Daily Living (ADL) Care, serving, and timeliness of meal trays incontinence care and turning and repositioning on 09/15/2021. 29). The Vice President of Operations, Director of Clinical Operations and Regional Nurse Consultants conducted a conference call on 09/15/2021 with a contract company for a consultation to review the following: (1) the outcomes of the survey; (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations; (3) determined a plan for the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). The Administrator and Regional Nurse Consultant reviewed and revised the QAPI Plan beginning 09/16/2021 and presented the reviews and/or revisions to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The agenda included reviewing pressure ulcers, Foley	{F 580}		

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{F 580}	Continued From page 44 catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, hospital readmission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns, grievances, admissions, discharges, census, staff development, vacant positions, employee orientation, dietary variances, tray audit report, weight loss, work injuries, terminations, employees on family medical leave, a leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include, but not limited to, the topics presented during the meeting. 31). The Regional Director of Operations and Vice President of Operations met with the Administrator, the DON, and the Medical Director on 09/16/2021 regarding the duties of the Governing Body, including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes with the utilization of the five (5) why approaches and, auditing systems per the QAPI Calendar. The Administrator will notify the medical Director of future QAPI Committee meetings. 32). The Administrator will collect all monitoring reports before each QAPI Committee meeting beginning 09/15/2021 for review to ensure compliance with the deficiencies cited during the	{F 580}		

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{F 580}	Continued From page 45 09/10/2021 survey. QAPI Meetings were held on 09/16/2021 to discuss abatement and develop interventions to remove the jeopardy. The facility implemented QAPI meetings weekly, times four (4) weeks, as needed, and monthly. The Administrator will forward all QAPI Meeting minutes to the Governing Body members, including the Vice President of Operations, Regional Vice President of Operations, and the Regional Nurse Consultant, to review the audit results. The QAPI committee will review the audits at the QAPI meetings. Committee for review. The Administrator oversees the QAPI Committee. The QAPI Committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 33). The Governing Body will provide the facility's Administrator with resources and education materials for QAPI, including but not limited to the QAPI Tool Kit, QAPI at a Glance, and a resource guide to effectively implement the QAPI plan beginning 09/16/2021. The Governing Body will meet quarterly for the upcoming year and reevaluate for frequency after one (1) year. 34). The Administrator will increase the frequency of QAPI Committee meetings to weekly for four (4) weeks and, as needed effective 09/16/2021, to ensure the quality of care is monitored and complies with the standard of care and compliance with State and Federal requirements is demonstrated. 35). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques,	{F 580}		

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{F 580}	Continued From page 46 obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. 36). On 09/13/2021, the Regional Certified Dietary Manager (CDM) educated the Dietary Manager on the provision of timely nutritional assessment to ensure diet order accuracy, on diet order accuracy, and on when to enter diet orders into the electronic medical record. The CDM educated the Dietary Manager to enter resident diet orders into the tray care system. If the nurse enters the order, the nurse will send a written communication to the dietary staff, including diet and texture. In the morning clinical meetings, staff will review diet orders from the previous day to ensure accuracy. 37). Therapy provided education to all nursing staff on turning and positioning range of motion, and transfer of resident from bed to chair and chair to bed beginning on 08/19/2021 and completed on 09/17/2021. The facility employed and assigned additional staff through recruitment and agency contracts to ensure adequate staff to turn and reposition all residents who cannot reposition themselves. 38). The Regional Director of Nursing educated all nursing staff on pressure ulcer prevention, including turning and repositioning, adequate hydration and nutrition, positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician, and RP of a new skin impairment by 09/17/2021. The facility nursing staff will call or email the Registered Dietitian, Physician, and Resident Representative of any new skin changes.	{F 580}		

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{F 580}	Continued From page 47 39). The DON or designee educated all staff on timely call light response. In addition, direct care staff, including nurses and certified nursing assistants, were provided education on providing timely hygiene per the resident's plan of care, timely toileting, dressing residents in their choice of clean clothing, and timely delivery of meal trays. The DON or designee will educate any facility staff not working during education upon returning to work. 40). On 08/31/2021, The Regional Director of Nursing educated all licensed nursing staff, the Registered Dietician, the Social Service Director, and the MDS Nurses on entering new care plans into the electronic medical record, including goals and interventions. In addition, the Regional Director of Nursing educated staff to update the existing care plan in the electronic medical record with new goals and interventions for any new skin impairments identified during their shift. 41). The facility's Respiratory Therapist educated Licensed nurses on identifying and assessing residents with a change in respiratory status on 08/12/2021. In addition, on 08/12/2021, the DON and/or designee educated all licensed nurses on identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a resident's change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. The facility licensed nursing staff will not be allowed to work until they have received this education. The DON educated all clinical staff on documentation of glucose levels on 08/19/2021 and 08/20/2021 during mandatory in-services.	{F 580}		

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{F 580}	Continued From page 48 42). Beginning 08/12/2021, the DON educated licensed nurses on completing a baseline Care Plan with interventions and goals relevant to diabetes and a respiratory diagnosis within 48 hours of admission, reviewing and providing a copy to the resident and/or the responsible party. Licensed nursing staff not working during education was notified of ongoing education and will not be allowed to work until they have received this education. 43). Beginning 08/12/2021, the DON educated all staff on the facility's "call off" procedure. The call-off procedure for the facility included: in the event a person needs to call out of work for dayshift, they are to notify their immediate supervisor two hours before the start of the shift. If staff needs to call off on the night shift, they are to notify their immediate supervisor four hours before the start of their shift. If the facility does not have appropriate staffing levels, the immediate supervisor and/or designee will call other qualified staff to replace the person calling off. If emergency staffing is required, the Administrator and/or designee will call for assistance from staffing companies. Staff not working will be in-serviced upon return to work. 44). All staff were provided re-education by the Administrator and/or designee on 08/12/2021 on the process of identifying, preventing, and reporting abuse, as well as identifying and implementing immediate interventions for wandering residents. 45). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques,	{F 580}		

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{F 580}	Continued From page 49 obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. On 09/13/2021, the CDM educated the Dietary Manager on diet order accuracy and timely nutritional assessment to ensure diet order accuracy. When staff enters diet orders into the electronic medical record, the nurse entering the order will send the written communication to the dietary staff. The Dietary Manager will enter the order into the tray care system. The facility will review diet orders from the previous day in the clinical meeting to ensure accuracy. 46). The Regional CDM educated the Dietary Manager on 09/13/2021 on facility policy regarding meal service times and the use of recipes including recipes for those requiring fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural and ethnic needs of the population. 47). As of 09/15/2021, the Regional CDM completed education with the dietary manager on obtaining food preferences, the facility's tray card system, ordering food based on menus, stocking snack/hydration carts, snacks, and hydrations procedures, appropriate scoop sizes, and/or portion sizes. 48). The Director of Nursing or Regional Director of Nursing educated nurses and the Dietary Manager on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders on 09/17/2021. 49). All staff were provided re-education by the DON and/or designee by 09/17/2021 on the	{F 580}		

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{F 580}	Continued From page 50 COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. In addition, the DON/designee educated, licensed staff on monitoring residents for Covid-19 symptoms beginning. 08/12/2021, the DON/designee educated all staff, including contract staff, who were not working. During the QAPI meeting on 08/12/2021, the Covid-19 policy, the handwashing policy, donning and doffing PPE, red and yellow zones, and monitoring residents for signs/symptoms of the Covid-19 were reviewed. 50). Staff were provided re-education on 08/20/2021 by the DON, Regional DON, or Regional Nurse Consultant to enter COVID-19 symptom monitoring orders on all new admissions into the resident's record. 51). All licensed nursing staff have been educated on the five (5) rights of medication administration, including right medication, right patient, right dose, right time, and right route. The Regional DON/DON/designee educated all licensed nursing staff working on 09/23/2021 on the process to follow when a medication was not available for administration as ordered. The education included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notify the MD if an ordered medication will either be omitted or given outside of the ordered medication time. The education also included following new orders given by the MD, documenting the conversation, and new orders from the MD in the electronic medical record. All other licensed nursing staff will be provided training as scheduled for shifts.	{F 580}		

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{F 580}	Continued From page 51 52). On 09/25/2021, the DON /Regional Nurse Consultant educated all licensed nursing staff, including new hires and/or agency staff, on the use of the emergency medication kit, the system in place for ensuring medications are in-house, or notifying the physician for new orders for new or re-admitting residents, including on weekend and after-hours. 53). The Interim Administrator educated all staff on his contact information and role as the Abuse Coordinator from 09/13/2021 through 09/17/2021. In addition, education on staffing schedules and who to notify if unable to work their scheduled shift. 54). The facility will audit weekly resident head-to-toe skin assessments daily, Monday through Friday, for three (3) months effective 09/17/2021 to ensure they have been completed weekly on each resident. In addition, the facility will notify the physician, Registered Dietician, and Responsible Party of any new skin impairment and those new interventions have been put in place to prevent decline. 55). Central supply audited all lab supplies for the expiration date on 08/28/2021. Audits will be conducted weekly for all lab supplies for four (4) weeks effective 09/17/2021 and then monthly for three (3) months. 56). The Director of Nursing, Assistant Director of Nursing (ADON), or Nursing Supervisor will audit resident progress notes for daily four (4) weeks effective 09/13/2021, then weekly for one (1) month. Staff will review Progress notes for Saturday and Sunday on Monday. The Nursing Supervisor conducted audits to ensure any new	{F 580}		

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{F 580}	Continued From page 52 areas of skin impairment identified had a care plan implemented to include new interventions. 57). Beginning on 09/11/2021, the facility's leadership staff and/or designee began visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning. All residents will be visually rounding on once each shift daily for two (2) weeks, fifty percent of the residents each shift for four (4) weeks, and twenty-five percent of residents each shift for four (4) weeks. The facility has two (2) shifts, 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 58). On 09/11/2021, the facility's leadership staff began visual monitoring and timing of call light response times, including the length of time call lights are answered, across all shifts. Leadership staff will conduct ten (10) call light observations each shift for two (2) weeks and then five (5) call light observations each shift for eight (8) weeks. 59). On 08/13/2021, the DON and/or Designee began monitoring respiratory assessments and Situation Background Assessment and Recommendation (SBAR) communications for acute change in respiratory status Monday through Friday in the clinical morning meeting. The facility reviewed any acute change in respiratory status for Physician notification and implementation of any physician order. Care Plans were reviewed and updated as needed. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 60). The MDS Nurse, DON, and/or Designee began audits on 09/15/2021 of baseline care plan completion for all new admissions and re-admissions to ensure staff completed the	{F 580}		

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{F 580}	Continued From page 53 baseline Care Plan within 48 hours of admission. 61). All residents admitted within the last thirty days with a diagnosis of Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Asthma, or current Pneumonia had their baseline Care Plan reviewed and updated as needed by the MDS Nurse(s) and/or designee. New interventions will be added to the care plan in the morning meeting by the DON, ADON, and/or nursing designee. 62). Beginning on 08/19/2021, the MDS Nurse, DON, and/or Designee will monitor new admissions and re-admissions to audit baseline care plans for completion, accuracy, and review with the resident and/or responsible party. Any variance or identified concern was addressed immediately. Audits will be conducted Monday through Friday for all admissions/re-admissions to the facility for four (4) weeks, fifty percent of admissions for a week for two (2) weeks, and then ten percent of admissions weekly for four (4) weeks. 63). On 09/11/2021, the Dietary Manager and/or designee began auditing how long it took to pass meal trays to residents after arriving at the unit. All three (3) meals will be observed on all three (3) units daily for two (2) weeks, two (2) meals on all three (3) units daily for two (2) weeks, and one (1) meal on all three (3) units daily for four (4) weeks. 64). On 08/15/2021, the DON and/or Designee began audits of staff's knowledge with a verbal quiz of identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia,	{F 580}		

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{F 580}	Continued From page 54 the facility's diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician's orders. Leadership will quiz staff randomly across all shifts; ten (10) staff for one (1) week and five (5) staff a week for four (4) weeks. 65). On 08/13/2021, the DON and/or Designee began monitoring all documented blood sugar results Monday through Friday in the clinical morning meeting. The DON/designee will review any blood sugar results outside of the normal range for MD notification and implementation of any Physician's Orders. Care plans will be reviewed and updated as needed. The DON or designee will complete a visual rounding on diabetic residents across both shifts and all three (3) units to identify any resident with apparent signs and symptoms of hypoglycemia/hyperglycemia to ensure the resident was immediately assessed by licensed staff. Any variance or identified concerns will be addressed immediately. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 66). On 08/13/2021, the Administrator and/or designee implemented an employee questionnaire on abuse and identification of residents with wandering behavior to determine the proper reporting of abuse across all shifts and units. The employee questionnaire will be completed for five (5) staff daily for one (1) week, then three (3) times a week for two (2) weeks, and then weekly for four (4) weeks. Any variance or identified concerns will be addressed immediately. 67). Beginning on 08/13/2021, the Director of	{F 580}		

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{F 580}	Continued From page 55 Nursing and/or designee will review each resident's wandering risk assessment upon admission and quarterly with their Minimum Data Set (MDS) assessment. Any resident identified as wandering will be discussed in the clinical morning meeting to review and initiate new interventions. Any variance or identified concerns will be addressed immediately. New interventions will be care planned in the morning meeting by the Director of Nursing, Assistant Director of Nursing, or nursing designee. 68). Beginning on 08/13/2021, the Social Services Director or designee will perform random interviews of residents with a BIMS score of eight (8) or greater to ensure they feel safe in the facility and have not been subject to or witnessed abuse. The DON or designee will review random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure no injuries of unknown origin beginning 08/13/2021. Any variance or identified concerns will be addressed immediately. 69). On 08/25/2021, the Registered Dietician conducted audits of resident diet orders from the electronic medical record against orders entered in the diet/tray card software to ensure accuracy. 70). Beginning on 08/23/2021, the Dietary Manager will ensure and audit meals leaving the kitchen and reaching the units timely. Audits will be conducted for random meals twice daily for one (1) week, twice per week for two (2) weeks, and then weekly for one (1) month. Once meal trays arrive at the unit, management staff will assist in passing trays to ensure residents receive meal trays, and certified nursing assistants assist residents promptly. The Dietary Manager or	{F 580}		

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{F 580}	Continued From page 56 designee will audit the time it takes to pass meal trays to residents after they arrive on the unit beginning 09/11/2021. All three (3) meals will be observed on each unit daily for two (2) weeks, two (2) meals on each unit daily for two (2) weeks, one (1) meal on each unit daily for four (4) weeks. 71). The dietary manager or designee will review admitted/re-admitted residents' food and beverage preferences within 72 hours of admission and enter them into the diet/tray card system for listing on their tray cards beginning 09/16/2021. Review of food preferences will be completed bi-annually and as needed for all residents. Physician-ordered snack intakes will be audited by the Dietary Manager daily for one (1) week, weekly for four (4) weeks, and monthly after that for four (4) months beginning 09/15/2021. 72). Daily COVID-19 screenings for staff will be audited beginning on 08/25/2021 by the Human Resources (HR) Director against time clock punches to ensure screening before beginning their shift. Audits will be completed Monday through Friday for four (4) weeks by the HR Director, and weekends audited on Mondays. Any staff not screened will be re-educated immediately on the COVID-19 Screening Policy by the HR Director. The HR Director was educated on the COVID-19 policy by the Regional Nurse, an infection control preventionist. All entry doors will remain locked. Visitors must be allowed entry by staff and screened by staff at the time of entry. 73). Beginning on 09/17/2021, the DON and/or designee will round seven (7) times each week	{F 580}		

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{F 580}	Continued From page 57 for eight (8) weeks, five (5) times weekly for four (4) weeks to audit infection control compliance on differing shifts and units. Audits will include observation of handwashing; isolation signage and zones; donning/doffing (putting on/taking off) PPE; and mask compliance. Any variance or identified concerns will be addressed immediately by the auditor. 74). The DON, ADON, and/or Designee will review all residents on narcotics with the pharmacy to ensure an active script is on file beginning 09/23/2021. Staff will notify the physician within two (2) days of the prescription's expiration. 75). The Regional Nurse Consultant, Pharmacy, and/or Director of Nursing will conduct random medication pass observations effective 09/25/2021 on random shifts daily until immediate jeopardy removed to ensure timeliness and accuracy of medications. The facility utilized the CMS Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. 76). Beginning 09/25/2021 Monday through Friday, the DON, ADON, and/or Designee will audit medication delivery tickets against ordered medications daily to ensure that all narcotics needing a renewal have been sent to the pharmacy. Audits will continue until the Immediate Jeopardy is removed. 77). Beginning 09/11/2021, the Administrator and/or DON will be responsible for monitoring nursing staff daily for four (4) weeks to ensure adequate staffing is maintained.	{F 580}		

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{F 580}	Continued From page 58 78). Beginning 09/11/2021, the Administrator and Dietary Manager will be responsible for reviewing dietary staffing daily for four (4) weeks to maintain adequate staffing. 79). Beginning 09/11/2021, the Divisional Vice President of Operations and/or designee will monitor and audit the Administrator daily for 30 days to ensure compliance. 80). Visual rounding will be conducted beginning 09/23/2021 to monitor for residents' change of condition and identification of need for "Stop and Watch" (change of condition) communication. 81). Beginning 09/11/2021, the Administrator or designee performed interviews of residents with a BIMS score of eight (8) or greater to ensure they felt safe in the facility and had not been subjected to or witnessed abuse. No residents had any concerns. Interviews will continue to be conducted of residents by the Administrator or designees weekly until immediate jeopardy is removed. **The State Survey agency validated the facility's actions to remove the Immediate Jeopardy on 09/26/2021 as alleged by : 1). Review of Head-to-Toe Skin Assessments revealed staff assessed all residents in the facility on 09/11/2021. A review of the skin assessments revealed eight (8) residents (Residents #65, #324, #45, #14, #357, #27, #74, and #358) had current pressure ulcers with a total number of pressure injuries of twenty (20). A review of the comprehensive care plans for Residents #65, #324, #45, #14, #357, #27, #74, and #358 revealed staff updated the care plans to reflect	{F 580}		

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{F 580}	Continued From page 59 the resident's current pressure injuries. The facility completed the review on 09/17/2021. A review of the facility's census on 08/28/2021 revealed staff assessed all residents at risk for pressure ulcers with the Braden Scale. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed head-to-toe skin assessment on all residents on 09/11/2021. She further revealed that the facility identified twenty (20) total pressure injuries. She further stated that the facility completed the Braden Scale assessments on all residents on 08/28/2021. Continued interviews revealed the Interdisciplinary Team utilized the skin assessments and Braden Scale assessments to update the residents' care plans. She stated that Resident #65, #324, #45, #14, #357, #27, #74 and #358's care plans were updated to reflect current pressure injuries by 09/17/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed she updated all residents' care plans to reflect current pressure injuries by 09/17/2021. In addition, she completed a review of walking rounds on 09/15/2021 with Therapy Personnel, the Registered Dietician, the Medical Director, the DON, and the MDS Nurse for Residents #65, #324, #45, #14, #357, #27, #74 and #358. A review revealed the Interdisciplinary Team reviewed each resident's orders, current skin breakdown, care plan, and implemented changes as needed. 2). Review of Resident #65's medical record revealed the Medical Director assessed the resident on 08/25/2021 at 1:45 PM and noted a Stage four (4) pressure ulcer on the sacrum; a deep tissue injury (DTI) to the left and right heels; and a skin tear to the left inner leg. Review of	{F 580}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 580}	Continued From page 60 Resident #65's wound care note dated 08/26/2021 at 9:00 AM, revealed the sacrum wound measured, "13 cm (centimeter) (length) by 12.3 cm width and 0.2 cm depth with undermining at 10 o'clock measuring 2 cm and undermining at 12 o'clock that measures 1 cm, muscle exposed. No palpable bone, slough is present, partially removed with wound cleanser." The facility continued to treat the resident's sacral pressure ulcer with Aquacel Ag. A review of a wound evaluation completed on 09/15/2021 revealed Resident #65 had six (6) pressure ulcers, including a stage two (2) to the left superior calf measuring 1.2 cm (length) by 1.4 cm (width) by 0.1 cm (depth), stage one (1) to the right hip measuring 2.5 cm by 2 cm by less than 0.1 cm, stage two (2) to left hip measuring 1.2 cm by 0.8 cm x less than 0.1 cm, stage two (2) to left scapula measuring 1 cm by 0.2 cm by less than 0.1 cm, unstageable to right heel measuring 0.6 cm by 0.6 cm. and four (4) areas to the sacrum measuring 12 cm by 11.6 cm by 0.4 cm. Interventions in place for the resident included heel protectors while in bed, diet as ordered, weekly documentation of the wound, an air mattress to bed, nutritional supplements, and turning/repositioning. Observation of wound care for the sacral pressure ulcer on 09/29/2021 at 10:21 AM revealed the wound measured 13 cm by 11 cm by 0.3 cm with a scant amount of drainage and 95 percent granulation tissue. Resident #65 declined would not consent to the observation of other pressure areas. A medical record review revealed that on 09/21/2021 at 2:19 PM, Physician #1 determined the resident's weight loss and wounds were unavoidable. On 09/28/2021, Resident #65's family declined in-house wound care visits. Further review of the record revealed on 09/29/2021, staff notified the	{F 580}		

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{F 580}	Continued From page 61 physician of the decline in the resident's wound with no new orders. The resident was diagnosed with Failure to Thrive. 3). The facility admitted Resident #355 on 09/10/2021, completed a skin assessment on 09/10/2021, completed a Braden Scale on 09/10/2021, and completed a baseline care plan on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record revealed staff developed the comprehensive care plan on 09/21/2021. A review of Resident #355's re-admission revealed the resident had an admission skin assessment completed on 09/28/2021, Braden Scale on 09/28/2021, and a baseline care plan developed on 09/28/2021. 4). Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, Resident #308 on 09/29/2021 at 11:10 AM, Resident #309 on 09/29/2021 at 11:26 AM, Resident #311 on 09/29/2021 at 11:52 AM, Resident #314 on 09/29/2021 at 11:30 AM and Resident #320 on 09/29/2021 at 11:13 AM revealed the residents appeared clean, well-kempt, and clean linens were on the residents' beds. Interviews with the residents during the time of the observations revealed no identified concerns. A review of Progress Notes for Residents #45, #65, #308, #309, #311, #314, and #320) revealed the Interim Social Service Director interviewed the residents on 09/15/2021 and had no concerns with resident hygiene. Interview with the ISSD on 09/30/2021 at 2:23 PM revealed she interviewed Residents #45, #65, #308, #309, #311, #314, and #320 on 09/15/2021 with no identified concerns regarding hygiene.	{F 580}		

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{F 580}	Continued From page 62 5). Observation of residents during the initial tour on 09/28/2021 from 1:33 PM to 2:32 PM revealed no identified concerns. Interviews and record reviews revealed Residents #45, #65, #308, #309, #311, #314, and #320 each had their shower preference and hygiene preference obtained and included on their care plan. A review of the resident's medical record, including the comprehensive care plan and SRNA care plan, revealed staff updated each resident's plan to reflect the resident's preference. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM revealed she assisted with obtaining resident preferences. She stated each resident was interviewed for shower and hygiene preference, and the facility updated each resident's care plan. A review of resident interviews revealed their shower/hygiene preference was obtained. A review of the facility's shower schedule revealed that the resident shower/hygiene preferences were honored. 6). Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she began reviewing all resident diets on 08/28/2021. She further stated that she implemented new and/or additional recommendations for residents to address weight loss and/or wound healing. A review of the documentation revealed the Registered Dietician reviewed all residents' diets, and the Regional DON reviewed all diets and recommendations. Interview with the RDO on 09/30/2021 at 4:17 PM revealed she completed the review of all diets and recommendations. 7). A review of facility assessments completed by 08/13/2021 revealed thirty-nine (39) residents with a diagnosis of Diabetes were assessed for signs and symptoms of hypoglycemia/	{F 580}		

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{F 580}	Continued From page 63 hyperglycemia and the need for immediate intervention. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she assessed the residents and did not identify immediate concerns. Observations of Resident #348 on 09/28/2021 at 1:36 PM, Resident #320 on 09/29/2021 at 11:13 AM, and Resident #311 on 09/29/2021 at 11:52 AM revealed no visible signs/symptoms of hypoglycemia/hyperglycemia. A review of facility assessments completed on 08/12/2021 revealed fifty (50) residents with a diagnosis of Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by Respiratory Therapist #1. Interview with Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM revealed she assessed all residents with diagnoses of Chronic Obstructive Pulmonary Disorder (COPD), Asthma, and pneumonia 08/12/2021 with no identified concerns. Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, and Resident #43 on 09/28/2021 at 2:03 PM. revealed no respiratory distress. 8). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she reviewed all residents with a diagnosis of Diabetes and the resident's orders for glucose monitoring. She stated the facility amended all resident orders to include mandatory entry of glucose values on the MAR. Review of Resident #3, #41, and #357's orders revealed each order required staff to enter the glucose value on the resident's MAR. Further review revealed no concerns with residents having glucose levels less than 60 and/or greater than 400. 9). A review of audits completed on 09/11/2021	{F 580}		

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{F 580}	Continued From page 64 revealed meals were delivered timely. Interview with the Regional Certified Dietary Manager (RCDM) on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed lunch was observed on 09/11/2021 and arrived at the unit within five (5) to ten (10) minutes of the scheduled times. 10). A review of the facility's staffing for 09/28/2021 from 6:00 AM to 6:00 PM revealed two (2) licensed nurses and three (3) nursing assistants were scheduled for each floor of the facility. A review of the facility's staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. A review of the staffing for 09/29/2021 and 09/30/2021 revealed two (2) licensed nurses, and three (3) certified nursing assistants on each floor from 6:00 AM to 6:00 PM. Further review of staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. Observation of facility staffing on 09/28/2021 from 1:20 PM to 5:30 PM; on 09/29/2021 from 8:11 AM to approximately 6:00 PM and 09/30/2021 from 7:55 AM to 5:17 PM, revealed call lights were being answered timely, residents appeared clean/well-groomed, staff was offering and assisting residents with baths/showers, turning/repositioning was being conducted timely, and meal trays were passed timely. Interviews with RN #1 on 09/29/2021 at 11:55 AM and on 09/30/2021 at 12:58 PM; RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM; LPN (Licensed Practical Nurse) #6 on 09/30/2021	{F 580}		

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{F 580}	Continued From page 65 at 12:44 PM; LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM; LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM; State Registered Nurse Aide (SRNA/certified nurse aide) #1 on 09/29/2021 at 3:40 PM; SRNA #11 on 09/29/2021 at 3:23 PM; SRNA #7 on 09/29/2021 at 3:29 PM; SRNA #19 on 09/29/2021 at 4:10 PM; SRNA #21 on 09/29/2021 at 3:04 PM; SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed staffing had improved, and each staff member revealed they had time to perform duties as assigned. 11). Review of the staffing schedule for 09/28/2021, 09/29/2021, and 09/30/2021 revealed each day consisted of one (1) day cook, one (1) evening cook, one (1) prep cook, two (2) day aides, and two (2) evening aides. Observation of the kitchen on 09/28/2021 at 2:26 PM reflected the staffing was accurate per the schedule. Interview with Cook #3 on 09/29/2021 at 1:12 PM, and Dietary Aide #3 on 09/30/2021 at 2:10 PM revealed kitchen staffing had improved, and they were able to complete their duties during their shift. 12). A review of assessments for being withdrawn, crying, or other abuse symptoms was conducted for Residents #64, #86, and #322 on 08/11/2021. No concerns were identified. A review of skin assessments completed revealed no identified concerns. Observation and interviews conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with psychosocial and/or physical abuse, including observations of Residents #64, #86, and #322. Interview with Resident #322 on 09/29/2021 at 11:54 AM revealed no concerns	{F 580}		

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{F 580}	Continued From page 66 with abuse. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed all residents with a diagnosis of Dementia had their care plans reviewed and revised as necessary. Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed skin assessments on 08/11/2021, for all residents, with the assistance of licensed nursing staff. No concerns were identified. A review of audits completed by the Social Service Director (SSD) for residents with a BIMS score of eight (8) or above revealed no identified concerns. 13). A review of assessments for residents that wander, revealed all residents had received a wandering risk assessment by 08/16/2021. Review of the elopement/wandering binder at each nursing station on 09/29/2021 revealed a binder on each floor that contained information including a description, a photo and potential interventions for each resident identified at risk. 14). Review of Resident #39, #65, #81, #90, #330 and #332's medical record revealed all of the residents had been weighed by 09/17/2021. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she completed a comprehensive nutritional assessment on Residents #39, #65, #81, #90, #330 and #332. Review of the medical record revealed the RD completed a comprehensive nutritional assessment on 09/16/2021 for Resident #39, 09/16/2021 for Resident #65, 09/16/2021 for Resident #81, 09/16/2021 for Resident #90 and 09/16/2021 for Resident #330 with no dietary recommendations made. Resident #332 was discharged. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM, the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the	{F 580}		

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{F 580}	Continued From page 67 Regional DON on 09/30/2021 at 4:17 PM and DON #2 on 09/30/2021 at 3:20 PM revealed each resident had received a comprehensive nutritional assessment and review of the recommendations by nursing staff. Further interview with the RD and Regional DON revealed both the record and tray card were reviewed to reflect accurate information. 15). Observation of the third floor on 09/28/2021 at 2:22 PM, the fourth floor on 09/28/2021 at 2:00 PM and the fifth floor on 09/28/2021 at 2:06 PM revealed snacks including but not limited to oatmeal pies, goldfish crackers, cookies and drinks were present, including soda, milk, and juice. Observations on 09/29/2021 at 10:30 AM revealed snacks were being passed on third floor. Review of Resident #331, Resident #65 and Resident #14's record revealed documented intake of snacks. Interview with SRNA #19 on 09/29/2021 at 4:10 PM revealed she was educated on documentation of snacks. 16). Observation of the facility's red zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. The zones contained no residents. 17). Review of Residents #327, #328 and #329 revealed the residents were isolated per CDC guidance. Observation of Resident #328 on 09/29/2021 at 11:41 AM and Resident #329 on 8/30/2021 at 10:36 AM revealed no obvious signs or symptoms of COVID-19. Resident #327 had been discharged from the facility. 18). Review of facility staff testing revealed all staff working on 09/16/2021 were tested for COVID-19 with no identified new cases. Further	{F 580}		

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{F 580}	Continued From page 68 review of resident testing for COVID-19 on 09/17/2021, revealed no new cases. 19). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed the facility is testing staff two (2) times weekly. Interview with Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed she was conducting testing two (2) times weekly following CDC guidance. Review of facility staff tested revealed tested is being conducted two (2) times weekly. 20). Review of Resident #329, #328, #311, #65 and #90's medical record revealed that each resident had COVID-19 monitoring orders	{F 580}		

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{F 580}	Continued From page 69 implemented. In addition, review of each resident's MAR revealed staff was completing the monitoring as ordered by the physician. 21). Interview with the Medical Director on 09/30/2021 at 3:25 PM revealed Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351's medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). Observation of a medication pass on 09/29/2021 at 4:35 PM on 3rd floor and 09/30/2021 at 8:09 AM on 3rd floor revealed no identified concerns with missing medications. In addition, observation of a narcotic count on 5th floor on 09/30/2021 at 12:50 PM revealed no identified concerns. Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, N #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with unavailable medications. 23. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Co-Owner/President of Pharmacy on 09/30/2021 at 3:11 PM revealed both parties made a formal agreement that the pharmacy will supply the facility with a three-day supply for medication requiring cost review. Review of the facility's pharmacy agreement revealed for any medication requiring a cost review the pharmacy would send the facility a minimum of a three-day supply of the medication while being reviewed. The facility would communicate any changes or continuance	{F 580}		

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{F 580}	Continued From page 70 guidance to the pharmacy within 72 hours. The Director of Operations of Guardian Pharmacy and the Vice President of Operations of the facility signed the agreement. 24). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4 on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education and was aware of the process for obtaining medications from the pharmacy. In addition, they revealed they were aware that the nurse would notify the physician if the pharmacy could not deliver a medication to the facility. 25). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and Regional DON on 09/30/2021 at 4:17 PM revealed an audit was completed of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified concerns with missing medications. 26). Review of a QAPI signature sheet revealed the facility conducted a meeting on 08/12/2021 with the Regional DON, Regional Nurse Consultant, Human Resources, SSD #2, Medical Records, the Housekeeping Supervisor, Central Supply, MDS Nurse #1, MDS Nurse #2, the Therapy Manager, the Admissions Coordinator, the Administrator, the Activities Director, the Dietary Manager, and other members of the administration team.	{F 580}		

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{F 580}	Continued From page 71 27). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the facility appointed the current Interim Administrator on 09/13/2021. Further interview with the VP of Operations revealed she had provided the Interim Administrator with daily oversight since 09/10/2021. 28). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, the Medical Director on 09/30/2021 at 3:25 PM and members of the QAPI committee, including the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, revealed procedures for contacting staff for call-ins, answering call lights, ADL Care, serving and delivering meal trays timely, incontinence care and turning/repositioning were reviewed on 09/15/2021. 29). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and the Med-Net Concepts Nurse Consultant on 09/28/2021 at 3:00 PM revealed the facility conducted a conference call to review the following: (1) the outcomes of the survey, (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations, (3) determined a plan for the following communication/monitoring tools: Infection Control and COVID-19 isolation, enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing	{F 580}		

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{F 580}	Continued From page 72 appropriate ADLS, and providing a functioning QAPI committee. 30). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed reviewed and revised the QAPI Plan and presented the reviews and/or revision to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The plan included pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, the hospital re-admission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns and/ or grievances, admissions, discharges, census, staff development, openings by department/position, employee orientations, dietary variance tray audit report, weight losses, work injuries, terminations, employees on family medical leave of absence or leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include but not be limited to the topics presented during the meeting. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on	{F 580}		

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{F 580}	Continued From page 73 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM, revealed the information was presented at the QAPI meeting held on 09/16/2021. 31). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, the Interim Administrator on 09/30/2021 at 3:40 PM, DON #2 on 09/30/2021 at 3:20 PM, and the Medical Director on 09/30/2021 at 3:25 PM revealed a meeting was conducted on 09/16/2021 regarding the duties of the Governing Body including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes of system problems, utilization of the "5 why" approach and auditing systems per the QAPI Calendar were reviewed. 32). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he collected all monitoring reports before each QAPI meeting and reviewed the data for compliance. A review of QAPI attendance sheets revealed the facility conducted meetings on 09/16/2021, 09/23/2021, and 09/30/2021. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed they were members of the governing body, and QAPI meetings had been forwarded to them. 33). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Regional Nurse Consultant on 09/30/2021 at 3:40	{F 580}		

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{F 580}	Continued From page 74 PM revealed the governing body provided the Administrator with resources and education material for QAPI. Further interviews revealed the governing body would meet quarterly for the upcoming year. Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he had been provided with resources and education regarding QAPI. 34). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed QAPI meetings were conducted weekly effective 09/16/2021 to ensure the quality of care is monitored and complied with the standard of care and compliance. Further interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM revealed they had participated in the weekly QAPI meetings conducted on 09/16/2021 and 09/23/2021. In addition, an interview with the Medical Director/Physician #1 on 09/30/2021 at 3:25 PM revealed he participated in the weekly QAPI meetings on 09/16/2021 and 09/23/2021. Further interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed the weekly QAPI meeting had been conducted on 09/30/2021. A review of the facility QAPI meeting attendance	{F 580}		

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{F 580}	Continued From page 75 sheet reflected the above interviews with no identified concerns. 35). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on 09/17/2021. Interview with nursing staff revealed they verbalized understanding of weighing residents, obtaining, documenting, and reporting the weights to the Registered Dietician (RD). Interview with Regional DON on 09/30/2021 at 4:17 PM revealed staff was provided with education on 09/17/2021 on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician. 36). Interview with Former Activities Director and current Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on 09/13/2021 by the Regional Certified Dietary Manager (CDM) on diet order accuracy and timely nutritional assessments to ensure diet order accuracy. When staff enter diet orders into the electronic medical record, the nurse entering the order sends written communication to the dietary staff, which includes diet and texture. She further revealed that she entered the order into the tray card system to reflect the resident's diet	{F 580}		

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{F 580}	Continued From page 76 orders. She stated that all diet orders from the previous day would be reviewed in the clinical meeting. Interview with the Regional CDM on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she completed education with Former Activities Director/Dietary Manager #3. In addition, she stated that she had been on site to provide additional assistance during the transition to her new role. 37). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on turning/repositioning, range of motion and transferring residents from bed to chair and from chair to bed. Observations of turning, positioning, and wound care with RN #11 on 09/29/2021 at 10:21 AM for Resident #65 revealed no identified concerns. Interview with the Therapy Manager on 09/30/2021 at 1:18 PM revealed she provided staff with education beginning on 08/19/2021 regarding turning/repositioning, range of motion, and transferring a resident from bed. 38). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on	{F 580}		

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{F 580}	Continued From page 77 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on pressure ulcer prevention including turning and repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, MD and RP of a new skin impairment. The nurse will call or email the Registered Dietitian, the physician, and the resident's representative with any changes. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and the Regional DON on 09/30/2021 at 4:17 PM revealed they educated staff on pressure ulcer prevention including turning/repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician and RP of a new skin impairment. With any change to skin impairment, the nurse will call or email the Registered Dietitian for new recommendations, MD, and resident's representative. 39). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM,	{F 580}		

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{F 580}	Continued From page 78 Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on timely call light response. In addition, interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on timely call light response, providing timely hygiene per resident plan of care, timely toileting, ensuring staff dress residents in their choice of clean clothing and timely delivery of meal trays. Further interview with Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on meal service times. 40). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they received	{F 580}		

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{F 580}	Continued From page 79 education on ensuring new care plans were entered into the electronic medical record. Observation of RN #1 on 09/29/2021 at 11:55 AM revealed the nurse was able to demonstrate knowledge of the education with no identified concerns. 41). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on identification and assessment of residents with a change in respiratory status and on identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting resident change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. In addition, interviews revealed they received education on documentation of glucose levels. 42). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on	{F 580}		

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{F 580}	Continued From page 80 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on completing a baseline Care Plan with interventions and goals relevant to the diagnosis of diabetes and a respiratory diagnosis within forty-eight hours of admission, and reviewing and providing a copy to the resident/responsible party. 44). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 Aide on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they were educated on the process of identifying, preventing, and reporting	{F 580}		

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{F 580}	Continued From page 81 abuse as well as identifying and implementing immediate interventions for wandering residents. 45). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12.50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on proper weighing techniques, obtaining, documenting, and reporting of weight changes to the Registered Dietician. In addition, an interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she had received education on diet order accuracy and provision of timely nutritional assessment to ensure diet order accuracy. When the diet orders are put into the electronic medical record, the nurse entering the order will send a written communication to the dietary staff that will include diet and texture. She further revealed all diet orders from the previous day are reviewed in the clinical meeting, which occurs Monday through Friday, to ensure accuracy. 46). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on facility policy regarding meal service times and the use of recipes, including recipes for fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural, and ethnic needs of the population. 47). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on obtaining food preference, facility tray card system, order placement for meals,	{F 580}		

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{F 580}	Continued From page 82 snack/hydration pass, appropriate scoop sizes and/or portion sizes, stocking snack/hydration carts and snacks and hydrations. 48). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders. 49). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, DON #2 on 09/30/2021 at 3:20 PM, Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10.55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on	{F 580}		

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{F 580}	Continued From page 83 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they had received education on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. Observation of the red facility zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. No residents were in the red or yellow zones. Observations conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), or the yellow/red zones. 50). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education entering COVID-19 symptom monitoring orders on all new admissions. A review of newly admitted Resident #355 on 09/10/2021 revealed the resident had COVID-19 symptom monitoring entered in the resident orders. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had a COVID-19 symptom monitoring entered in the resident orders. In addition, a review of Resident #329, #328, #311, #65, and #90's medical records revealed each resident had COVID-19	{F 580}		

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{F 580}	Continued From page 84 monitoring orders implemented. 51). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the five (5) rights of medication administration including right medication, right patient, right dose, right time, and right route. In addition, they were educated on the process to follow when a medication was not available for administration, which included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notifying the physician if an ordered medication would either be omitted or given outside of the ordered medication time. The education also included following new orders given by the physician, documenting the conversation, and new orders from the MD in the electronic medical record. 52). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the use of the emergency medication kit (e-kit). Observation of floor three (3) on 09/29/2021 at 3:10 PM, floor four (4) on 09/29/2021 at 2:57 PM, and floor five (5) on 09/29/2021 at 2:50 PM revealed each medication administration room was equipped with an emergency medication kit. Interview with	{F 580}		

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{F 580}	Continued From page 85 LPN (LPN) #9 on 09/30/2021 at 2:27 PM revealed she was a new hire to the facility and had received education regarding the emergency medication kit. 53). Interview with DON #2 on 09/30/2021 at 3:20 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they were educated on the Interim Administrator's contact information and role as Abuse Coordinator. Observation of the facility on 09/28/2021, 09/29/2021, and 09/30/2021 revealed signage posted with the Interim Administrator's contact information and title of Abuse Coordinator posted throughout the facility. 54). Review of audits beginning 09/17/2021 of weekly head-to-toe skin assessments revealed no identified concerns. Observation of Resident	{F 580}		

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{F 580}	Continued From page 86 #27 skin and wound assessment on 09/30/2021 at 10:20 AM revealed no identified concerns. A review of the medical record for Resident #65, #324, #45, #14, #357, #27, #74, and #358 revealed the weekly wound assessments completed with physician and responsible party notifications. Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she was notified of new and/or worsening pressure ulcers and reviewed the residents as indicated. Interview with Medical Director on 09/30/2021 at 3:25 PM revealed that he was notified of new and/or worsening skin impairments and new interventions to prevent decline. He further revealed that he participated in QAPI meetings and discussed ongoing audits and care of residents. Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the QAPI team discussed all audits in QAPI meetings, including new and/or worsening pressure injuries and interventions implemented. 55). Interview with Central Supply on 09/29/2021 at 2:40 PM revealed she completed the audits of all laboratory supplies on 08/28/2021. She further revealed that the audits were conducted weekly for four (4) weeks and then monthly for three (3) months. A review of audits revealed no concerns. Observation of floor three (3), four (4), and five (5) supplies and review of the audits revealed no identified concerns. 56). Interview with the Regional DON on 09/30/2021 at 4:17 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed progress notes were audited during morning clinical meetings to ensure all new areas of skin impairment had been care planned with interventions to address the area of concern. A review of audits revealed	{F 580}		

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{F 580}	Continued From page 87 no identified concerns. 57). Interview with the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed he completed visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning in addition to other leadership staff. Review of audits revealed staff were auditing nails, clothes, body odor, incontinent clean and dry, toileted as requested or every two (2) hours, hair clean and combed, sheets and blankets clean, call light within reach, facial hair shaved if applicable and turned and repositioned. 58). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed they participated in visual monitoring, and monitoring call light response times including the length of time call lights go unanswered. Interviews revealed any call activated more than five (5) minutes were addressed with the staff. A review of audits revealed they were completed on different units and different shifts. 59). Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed audits of respiratory assessments and SBAR communication Monday through Friday in the clinical meeting. She further revealed that she assessed to ensure that any acute change in respiratory status and/or SBAR assessments completed had physician notification and/or implementation of physician orders. Review of Resident #315 SBAR completed on 09/26/2021, #324 SBAR completed on 09/27/2021, and #326 completed on 08/15/2021 revealed assessment, physician notification, interventions, and care	{F 580}		

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{F 580}	Continued From page 88 plans updated as indicated. A review of audits revealed no identified concerns. 60). Review of Resident #355, who the facility admitted on 09/10/2021, revealed the resident had a baseline care plan developed on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record for Resident #355 revealed staff completed the comprehensive care plan on 09/21/2021 (eleven (11) days after admission). A review of re-admission for Resident #355 revealed the resident had a baseline care plan developed on 09/28/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed all new admissions and re-admissions to the facility were being reviewed during the morning clinical meeting Monday through Friday to ensure completion. 61). Review of the admissions for the last thirty days from 07/16/2021-08/16/2021 revealed no concerns with baseline care plans. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new/admission baseline care plans were being updated as needed in morning meetings. 62). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new admission baseline care plans were being audited Monday-Friday for completion, accuracy, and to ensure a review was conducted with the resident and/or responsible party within 48 hours of admission/re-admission. Further interviews revealed the audits were conducted Monday through Friday. A review of the audits completed revealed they included resident name, admission	{F 580}		

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{F 580}	Continued From page 89 date, baseline care plan completion, care plan delivered to resident and/or responsible party, and education as needed. A review of the audits revealed no identified concern with completion dates as indicated. 63). Review of the audits completed by the DM and/or CDM revealed they were completed as stated with no identified concerns. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, and Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed trays were audited for to ensure they arrived on the unit and were passed timely. 64). Review of verbal quizzes revealed ten (10) staff members were quizzed for one (1) week beginning on 8/15/2021 with no needed education. Further review of verbal quizzes revealed five (5) staff members were quizzed for four (4) weeks from 08/22/2021 and completed on 09/13/2021 with no identified concerns. A review of the verbal quiz revealed staff was quizzed on respiratory status, hypo/hyperglycemia, and SBAR/physician notification. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed they performed verbal quizzes for identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician orders. Interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at	{F 580}		

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{F 580}	Continued From page 90 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, revealed they participated in verbal quizzes with facility staff. 65). Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed audits of documented blood glucose levels Monday through Friday in the clinical meeting. She further revealed that with any blood sugar less than 60 and/or greater than 40, the facility staff were expected to notify the physician, Responsible Party, and Registered Dietician and follow physician orders. The Regional DON stated she identified one (1) resident on 08/12/2021 to have a blood glucose level of 430 and one (1) on 09/20/2021 to have a blood glucose level of 465 with no documented evidence the licensed nurse followed the facility process. She provided education to both RN #2 and LPN #5. A Review of audits revealed no further concerns. A Review of education revealed RN #2 and LPN #5 received education regarding the facility process. 66). Review of verbal staff quizzes revealed staff was verbally asked signs and symptoms of abuse when to report, signs and symptoms of wandering and wandering interventions. A review of the verbal quizzes revealed five (5) staff were verbally quizzed daily for one (1) week from 08/13/2021 to 08/19/2021 with no identified concerns. Further review revealed verbal quizzes were conducted three (3) times a week for two (2) weeks from 08/21/2021 to 09/02/2021 with no identified concerns. A review of verbal quizzes revealed that verbal quizzes were conducted one (1) time per week for four (4) weeks from the week of 09/03/2021 to 09/24/2021 with no identified	{F 580}		

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{F 580}	Continued From page 91 concerns. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed each assisted in the completion of verbal staff quizzes. Further interview revealed that each staff member was verbally quizzed on the areas listed on the audit tool (signs and symptoms of abuse, when to report, signs and symptoms of wandering and wandering interventions), and any need for education was completed immediately with each quiz. Interviews with SRNA #11 on 09/29/2021 at 3:23 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM and Maintenance Assistant #1 on 09/30/2021 at 2:56 PM revealed they participated in verbal quizzes regarding abuse, when to report, wandering and wandering interventions. 67). Review of Resident #355 on 09/10/2021 revealed the resident had an admission wandering risk assessment completed on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had an admission wandering risk assessment completed on 09/28/2021. The resident was not identified to be at risk for wandering. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed that	{F 580}		

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{F 580}	Continued From page 92 MDS staff will schedule wandering risk assessments to ensure completion. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and DON #2 on 09/30/2021 at 3:20 PM revealed all-new admissions would be reviewed in the morning clinical meeting to ensure appropriate assessments, including the wandering risk assessment, had been completed. Further interviews revealed that residents identified as at risk for wandering would be discussed during this meeting and appropriate interventions implemented. 68). Review of interviews performed for residents with a BIMS score of 8 or greater revealed no identified concerns. Continued review revealed interviews were initiated on 08/13/2021 with ten (10) resident interviews completed for four (4) weeks then five (5) residents for eight (8) weeks. Interview with ISSD on 09/30/2021 at 2:23 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed they were assisting in completing audits with residents with no concerns identified. Review of audits initiated on 08/13/2021 for review of random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure there are no injuries of unknown origin revealed no identified concerns. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed they were completing audits as indicated with no identified concerns. Observation of skin assessment on 09/30/2021 of Resident #45 at 9:23 AM and on 09/30/2021 at 10:20 AM of Resident # 27 revealed no concerns with injuries of unknown origin. 69). Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she started	{F 580}		

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{F 580}	Continued From page 93 audits on 08/25/2021 of resident diet orders from electronic medical records against orders entered in the diet/tray card software to ensure accuracy. Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334 tray card on 09/29/2021 at 12:30 PM revealed diets were served as ordered by the physician. A review of audits revealed audits were conducted weekly for four (4) weeks. 70). Review of completed audits revealed random meals were audited twice daily for one (1) week beginning 08/23/2021. Starting 08/30/2021, random meals were observed two (2) times per week for two (2) weeks and then weekly from 09/13/2021 for one (1) month. Interview with Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed audits were performed as indicated. Further interviews revealed that meals were served as scheduled, including breakfast at 7:00 AM, lunch at 12:00 PM, and dinner at 5:00 PM. Observation on 09/28/2021 at 5:03 PM revealed the evening meal had been served on the third floor. Observation on 09/29/2021 lunch meal revealed meals arrived at the third floor at approximately 12:16 PM, the fourth floor at 12:16 PM and 12:24 PM, and the fifth floor at 12:34 PM and 12:49 PM. 71). Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334's tray card on 09/29/2021 at 12:30 PM revealed the meals honored resident preferences, including likes and dislikes. Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she	{F 580}		

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{F 580}	Continued From page 94 would be responsible for obtaining food and beverage preferences within seventy-two hours of admission and entering the preferences into the system. A review of audits revealed snack intakes were audited daily for one (1) week from 09/15/2021 to 09/21/2021. Further review of the audits revealed snacks were audited weekly beginning on 09/22/2021. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she audited snack intake and had not identified any concerns. 72). Interview with the Human Resource Director (HR) on 09/30/2021 at 10:48 AM revealed she completed audits for daily staff screening against time clock punches. She revealed no identified concerns. Observation of entry doors on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no concerns. 73). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed audits were being conducted with observations of handwashing, isolation signage and zones, donning/doffing PPE, mask compliance. Any variance or identified concerns will be addressed immediately. A review of the audits revealed they were conducted beginning 09/17/2021 on random shifts and units. 74). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she was responsible in addition to other members to review all residents on narcotics with the pharmacy to ensure that an active script is on file	{F 580}		

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{F 580}	Continued From page 95 beginning 09/23/2021. A review of audits revealed no identified concerns. RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with obtaining scripts for medications and/or receiving medications timely. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified concerns with missing medications. In addition, observation of the narcotic count on the fifth floor on 09/30/2021 at 12:50 PM revealed no identified concerns. 75). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she was responsible for completing random medication pass observations beginning 09/25/2021. She stated she had not identified any concerns with residents not having medications or narcotic counts. A review of audits revealed the facility utilized the Centers for Medicare Services Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. A review of audits revealed a minimum of twenty-five medications were observed daily from 09/25/2021 with no identified concerns. Further review of medication observations revealed that medication administration was observed on random shifts, including 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 76). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM. The DON on 09/30/2021 at 3:20 PM revealed medication delivery tickets were being reviewed in clinical	{F 580}		

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{F 580}	Continued From page 96 meetings Monday through Friday against ordered medications. A review of the audit revealed no identified conc	{F 580}		
{F 584} SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	{F 584}		12/30/21

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{F 584}	Continued From page 97 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to provide a clean, comfortable, and homelike environment for nine (9) of fifty-seven (57) sampled residents (Resident #3, Resident #321, Resident #17, Resident #96, Resident #316, Resident #86, Resident #39, Resident #92 and Resident #332). The facility failed to ensure Resident #316 and Resident #86 had a clean and odor free bathroom; Resident #39 had clean linens; and Residents #39's and #3's floor was free from soiled linen. Additionally, the facility failed to ensure Resident #96, Resident #86, Resident #316 and Resident #15 had properly functioning shower/bath equipment when the showerhead in the unit shower room was broken and non-functioning for five (5) days before being repaired. The findings include: Review of the facility's policy titled, "Quality of Life-Homelike Environment", revised on 05/2017 revealed residents were provided with a safe, clean, comfortable, homelike environment and	{F 584}	F 584 Safe/Clean/Comfortable/Homelike Environment Criteria 1: a) The bathroom for residents #316 and #86 was deep cleaned and sanitized to address any lingering odors. b) Resident #39 is provided clean linens. c) Staff remove soiled linen from the room for Resident #39 and #3. d) The showerhead in the unit shower room for Residents #96, #86, #316 and #15 was repaired and is in proper working order. Criteria 2: a) On 11/1/2021 the Director of Maintenance, and/or Director of Housekeeping and/or Administrator identified an repairs or cleaning issues to be addressed in resident care and common areas, all identified issues were prioritized and/or put on a schedule. Criteria 3: a) Maintenance staff have received in-service education on 11/1/21	

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{F 584}	Continued From page 98 encouraged to use their personal belongings to the extent possible. Further review revealed staff and management shall maximize, to the extent possible, the characteristics of the facility that reflected a personalized, homelike setting. These characteristics included: a clean, sanitary and orderly environment, comfortable yet adequate lighting, inviting colors and décor, personalized furniture and room arrangements, clean bed and bath linens that were in good condition, pleasant neutral scents, plants and flowers where appropriate, comfortable and safe temperatures (71- 81 degrees Fahrenheit), and comfortable noise levels. Further review revealed the facility's staff and management shall minimize, to the extent possible, the characteristics of the facility that reflected a depersonalized, institutional setting. These characteristics included: overhead paging, institutional odors, institutional signage, medication carts, and chair and bed. 1. Observation on 07/27/2021 at 10:45 AM revealed trash and soiled laundry and linens on the floor in residents' rooms #312 and #316. Further observation revealed the floors and bedside tables were soiled with sticky substances throughout the rooms on the third floor. Soiled linens were observed on the floor of Resident #39's room. Odors of feces and urine were noted in residents' rooms with full urinals sitting on the floor in Resident #332's room. Observations and interview with Resident #332 on 07/27/2021 at 11:00 AM revealed he/she was setting on the side of his/her bed and the resident's urinal was full of urine. Continued observation revealed urine spilled onto the floor as the resident held the urinal. A strong odor of urine was noted in the resident's room, and on	{F 584}	by the Director of Maintenance/Administrator/Designee on maintaining a safe/clean/comfortable/homelike environment which included but was not limited to: completing monthly maintenance audits to maintain equipment function and identify the need for any repairs; and the need to check for and address all maintenance requests timely. b) Housekeeping staff have received in-service education on 11/1/21 by the Director of Housekeeping/Administrator/Designee on maintaining a safe/clean/comfortable/homelike environment which included but was not limited to: completing monthly housekeeping audits to identify any cleaning issues; and the need to identify and address cleaning issues during daily assignments. Criteria 4: a) The Administrator will review/sign off on the weekly TELS work order completion audits completed by the Maintenance and Housekeeping departments beginning first week of November 2021 b) The Administrator/designee will complete random audits of the facility , auditing one unit on different days of the week so that each patient care unit is audited weekly to identify any maintenance or housekeeping issues weekly x 4 weeks then monthly x 2 months beginning week of November 22, 2021. Audits will be reviewed in QAPI	

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{F 584}	Continued From page 99 the resident's person. Resident #332 stated, "I am always spilling pee all over the place because I can't get anyone to empty this for me." referring to his/her urinal. Further observations revealed the floor in the residents room had a sticky substance and the State Survey Agency's Surveyor's shoes stuck to the floor while observations were conducted. Three (3) pieces of bread and soiled linen were also observed on the floor by the resident's bed. Observation of Resident #17 on 08/05/2021 at 11:02 AM revealed a fitted sheet with a large brown discoloration and two (2) pillows without pillow cases. Interview with Resident #17 revealed that he/she would like to have clean linens and pillow cases on his/her two (2) pillows on the bed. Review of Resident #17's medical record revealed the facility admitted him/her on 03/15/2021 with Diabetes, Hypertension and Cancer. Review of his/her Quarterly MDS assessment dated 06/16/2021 revealed the resident had intact cognition with a BIMS score of 15. Interview with Resident #39, on 07/27/2021 at 10:50 AM, revealed his/her sheets were not changed unless he/she requested them to be changed. Resident #39 stated that soiled washcloths and linens were placed on the floor of his/her room and stayed until housekeeping picked them up. Interview with Resident #3 on 07/27/2021 at 11:00 AM revealed the facility piled his/her soiled laundry on the floor until housekeeping picked it up.	{F 584}	monthly x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance: 12/30/2021	

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{F 584}	Continued From page 100 Interview with Family Member #1, on 07/28/2021 at 2:19 PM, revealed Resident #321 had dirty blankets and washcloths. She stated the blankets were stained when provided, and when the blankets were soiled with pus and blood they stuck to the resident. Further interview revealed the facility had no clean blankets or washcloths available to provide to him/her. Interview with State Registered Nurse Aide (SRNA) #4, on 07/28/2021 at 7:35 PM, revealed resident rooms were dirty and the floors in the residents' rooms were not cleaned regularly. She stated some of the curtains in the rooms had feces on them and housekeeping never changed the curtains or mopped the floors in the resident rooms. She further stated they used to check the rooms for cleanliness, but no one seemed to care now. SRNA #4 stated the residents' rooms were "nasty", and it had never been like that before. Interview with the Housekeeping Supervisor, on 07/27/2021 at 4:08 PM, revealed if stains were present on blankets, linens, or washcloths, the facility would re-wash those items. She further stated all clean linens were visually checked daily by housekeeping staff and disposed if stains remained present after being laundered. However, the Housekeeping Supervisor stated linens were not checked again when sent to the resident floor. Per the Housekeeping Supervisor, resident rooms were checked weekly for cleanliness. She stated staff was expected to pick up soiled linen, laundry, and trash from resident rooms timely to ensure a clean environment for residents. She stated this was expected to be done daily.	{F 584}		

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{F 584}	Continued From page 101 2. Observation on 07/27/2021 at 11:45 AM revealed Resident #316 and Resident #86's shared a restroom and the toilet was full of feces and urine. Significant odor was noted throughout both resident rooms. Interview with Resident #316, on 07/27/2021 at 11:45 AM, revealed his/her restroom toilet had been full of feces and urine for a couple of days and smelled bad. Resident #316 stated he/she could not use the restroom and he/she was having to go across the hall to another resident's room to use the restroom. He/she further stated the facility said they would fix it, but they had not. Interview with Resident #86, on 07/27/2021 at 11:55 AM, revealed his/her toilet had been out of order and full of feces and urine for about two (2) days. He/she further stated it was a shared restroom, "it stinks", and no one had come to fix it yet. Interview with Resident #15, on 07/27/2021 at 12:15 PM revealed Resident #316 and Resident #86, were having to use his/her restroom because their restroom was out of order and full of feces and urine. Resident #15 stated it was bad Resident #316's and Resident #86's toilet was not fixed and it was not their fault. Interview with the Maintenance Supervisor, on 07/27/2021 at 4:00 PM, revealed maintenance issues were reported by staff placing repair slips in the maintenance boxes located on each resident floor. He stated the boxes were checked two (2) to three (3) times daily, and if immediate attention was needed, maintenance would make repairs immediately. The Maintenance Supervisor stated he was not aware until "today"	{F 584}		

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{F 584}	Continued From page 102 that Resident #86 and Resident #316's shared toilet was clogged and full of feces/urine. 3. Observation of 5th floor shower room on 07/27/2021 at 12:20 PM revealed a new shower head had been installed with the old showerhead in the tub in the shower room. Interview with Resident #96, on 07/27/2021 at 12:10 PM, revealed the shower head on the unit/floor was not working and had been broken for about a week. Interview with SRNA #7, on 07/27/2021 at 12:15 PM, revealed the shower head on the fifth floor had been broken. She stated staff reported to maintenance when repairs were needed. They could fill out a slip and put in maintenance box or call maintenance. Interview with the Maintenance Supervisor, on 07/27/2021 at 4:00 PM, revealed he was not aware the shower head on the 5th floor was broken until two (2) days ago. He stated he had replaced it just that morning. Per the Maintenance Supervisor, maintenance issues were reported by staff placing repair slips in the maintenance boxes located on each floor. He further stated the boxes were checked two (2) to three (3) times daily, and if immediate attention was needed, maintenance would repair them immediately. Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed she expected resident rooms to be clean and free of trash and no soiled linen or laundry on the floor. She further stated resident rooms were expected to be mopped and odors minimized. She stated housekeeping was expected to check rooms for cleanliness. The	{F 584}		

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{F 584}	Continued From page 103 Administrator stated staff was expected to call and notify maintenance of any immediate repairs and those repairs were expected to be done timely. The Administrator stated unclean rooms, soiled linens, or non-working toilets and shower equipment were not acceptable. 4. Review of Resident #92's medical record revealed the facility re-admitted him/her on 04/15/2021 with Diabetes, Chronic Kidney Disease and Cellulitis. Review of his/her Quarterly MDS assessment dated 06/30/2021 revealed the resident had moderately impaired cognition with a BIMS' score of 09. Observation of Resident #92's toilet on 08/05/2021 at 11:00 AM revealed an elevated toilet seat with stool smeared on the back rim. Interview with Resident #92 revealed that the stool has been there for hours and the "staff will not clean it when {he/she} tells them". The resident stated that the facility not being clean "bothers" him/her. Observation of Resident #92's elevated toilet seat on 08/05/2021 at 11:54 AM revealed stool still smeared on the back rim. Resident #92, again stated that the facility not being clean "really bothers" him/her.	{F 584}		
{F 585} SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with	{F 585}		11/30/21

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PARKVIEW POST-ACUTE AND REHABILITATION CENTER	200 NURSING HOME LANE PIKEVILLE, KY 41501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 585}	Continued From page 104 respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman	{F 585}		

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{F 585}	Continued From page 105 program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement	{F 585}		

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{F 585}	Continued From page 106 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility grievance policy, it was determined the facility failed to resolve grievances related to dietary/food complaints for one (1) of fifty-seven (57) sampled residents (Resident #156). Resident #156 complained to the facility about dietary/food service on 04/26/2021; however, there was no documented evidence the facility utilized their grievance procedure to investigate, document and resolve the grievance for Resident #156. The findings include: Review of the facility's grievance policy titled "Grievances/Complaints, Recording and Investigating" with a revision date of April 2017, revealed the grievance/complaint form would be completed for all grievance and complaints and a grievance officer would investigate the grievance/complaint. The Grievance Officer would report findings to the administrator and attach the investigation to the grievance/complaint form and the grievance results were made available to the person acting on behalf of the resident. Review of the closed medical record for Resident	{F 585}	F 585 Grievances Criteria 1: Resident #156 discharged from facility on 5/11/21 Criteria 2: a) A resident council meeting was held on 10/7/21, with residents in attendance asked if they had any concerns/grievances that they had reported that had not been resolved to their satisfaction. There were no unresolved issues reported. b) Residents with a BIMS score of 8 or higher that did not attend the resident council meeting conducted on 10/7/21 were interviewed by the Director of Social Services/Designee to determine if they had any concerns/grievances that they had reported that had not been resolved to their satisfaction. There were no unresolved issues reported. Criteria 3: Inservice education was provided by the Director of Social Services/Administrator or Designee for all staff on the facility policy and procedure for the reporting of concerns/grievances which included but was not limited to: the	

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{F 585}	Continued From page 107 #156 revealed the facility admitted the resident on 03/05/2021 with diagnoses, which included Diabetes Mellitus Type II and Morbid Obesity Due To Excess Calories. Review of Resident #156's Quarterly Minimum Data Set (MDS) Assessment, dated 04/02/2021, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) Score of fifteen (15) out of fifteen (15), which indicated the resident was cognitively intact. A review of Resident #156's Nutrition Progress Notes, dated 04/27/2021 at 05:53 PM, revealed the Dietitian and Dietary Manager had spoken with the resident on 04/26/2021 for forty-five (45) minutes and the resident had voiced complaints regarding dining services. According to the note, the resident expressed satisfaction with the outcome of the conversation. Interview with the Dietary Manager (DM), on 06/17/2021 at 8:05 PM, reveled the DM had not completed a grievance/complaint form because she was not aware of the facility's grievance procedure. The DM stated she was unaware she was required to complete a grievance/complaint form and send the form to the facility grievance officer or the administrator. Further interview revealed the DM had started at the facility in January 2021 and was not trained on the facility grievance/complaint procedure. Interview with the Social Worker, on 06/17/2021 at 2:12 PM, revealed she was the person responsible for reviewing and investigating grievances and was not aware of any complaints related to food for Resident #156. The Social Worker stated she had not received any	{F 585}	form to use for documenting concerns/grievances and where to locate these; who they are to provide the completed concern/grievance form; the need to complete follow up documentation on all reported concerns/grievances as assigned. Criteria 4: Beginning with December monthly resident council the minutes will be reviewed for any concerns/grievances by the Activities director or designee and Activities director or designee will provide concern/grievance to individual discipline specific to concern/grievance at next stand-up meeting to investigate and work toward resolution. Beginning on 11/22/21 at daily stand-up meeting mock survey rounds will be reviewed for any concerns/grievances, any concerns/grievances identified will be presented to individual discipline to investigate and work toward resolution. All disciplines who have been presented a concern/grievance will provide update daily in stand-up meeting as they work toward resolution. Social services director and/or designee will provide proper concern/grievance form to be completed by individual discipline. Social Services director and/or designee will monitor follow up and investigations in daily stand-up meeting. Administrator or designee will review grievances/concern weekly beginning 11/1/2021 x4 weeks then monthly for two (2) months with Social Service director or designee to ensure investigation and follow up is completed. Audits will be reviewed	

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{F 585}	Continued From page 108 grievance forms/investigations related to food complaints or dietary concerns for Resident #156. Interview with the Former Administrator, who was the administrator of record on 04/26/21, on 06/17/2021 at 8:25 PM, revealed he was aware of Resident #156's food complaints. According to the Administrator, he instructed Dietary to talk with the resident to attempt to resolve the resident's food complaints/concerns and was not aware grievance forms had not been completed. According to the Administrator, he did not consider the complaints grievance because the resident complained often about the food and would often change his/her mind. Per the Administrator, if grievance forms were not completed there was a potential for the resident's grievance not being resolved or addressed. Interview with the current Administrator, on 06/19/2021 at 1:30 PM, revealed she started employment at the facility in early June 2021. The Administrator stated this week during the morning meetings staff had discussed concerns with grievances and how staff, including the Social Worker, were not investigating the grievances. The Administrator stated all grievance should be forwarded to her for action.	{F 585}	monthly x3 months during QAPI meeting then quarterly until in substantial compliance. Criteria 5: Date of compliance: 11/30/2021	
{F 600} SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	{F 600}		12/30/21

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{F 600}	Continued From page 109 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy it was determined the facility failed to have an effective system to ensure four (4) of fifty-seven (57) sampled residents were free from abuse (Resident #64, #82, #86 and #322). Interviews and record reviews revealed the facility admitted Resident #82 on 05/12/2021 and since admission, the resident exposed him/herself numerous times to other residents, wandered in/out of other resident's rooms and was verbally/physically abusive to other residents. However, the facility failed to implement effective interventions to prevent Resident #82 from abusing other residents. Resident #82's ongoing behaviors resulted in resident-to-resident abuse incidents and on 05/18/2021, Resident #82 grabbed Resident #322 causing a skin tear. On 06/04/2021, Resident #82 grabbed Resident	{F 600}	F 600 Free from Abuse and Neglect Criteria 1: a) Resident #82 was discharged on 8/9/21. b) Residents #64, #86, and #322 were reassessed by the regional Director of Nursing via observation for new skin impairments, withdrawn and or crying behaviors and psychosocial of physical signs of abuse on 8-11-2021. There were none identified. Criteria 2: a) All in house residents were reassessed by the Regional Director of Nursing, wound nurse or designee via observation for new skin impairments, withdrawn and/or crying behaviors and physical signs of abuse on 8-11-2021. There were none identified. b) On 9-7-21 residents with	

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{F 600}	Continued From page 110 #64's wrist and would not let go; On 06/30/2021, Resident #317 held Resident #82's wrist because Resident #82 wandered into his/her room and would not leave; On 07/15/2021, Resident #82 hit Resident #86 with a shoe causing a large bruise to the resident's upper arm and on 07/31/2021, Resident #82 hit Resident #64 on the left wrist. Interviews with residents and staff revealed Residents #64, #86 and #322 were afraid of Resident #82. Interview with Resident #86 on 07/27/2021 revealed he/she was afraid when he/she went to sleep because Resident #82 still came in his/her room and the facility had taken no action to protect the resident. The facility's failure to have an effective system in place to ensure residents were free from abuse, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656) 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional	{F 600}	a diagnosis of dementia had their Care Plan reviewed and revised as necessary, by MDS Coordinator. d) Beginning 11-21-2021 licensed nurses and designees performed re- interviews of residents with the most recent BIMS score of 8 or greater to ensure that they feel safe in the facility and if they have any concerns. No residents had any concerns. Interviews were completed 11/22/2021. No concerns were identified. e) The Regional Nurse consultant completed a wandering risk assessment on all residents by 8-16-21. All residents who were identified as at risk for wandering had care plans reviewed and updated by MDS Coordinator. Criteria 3: a) All staff were re-educated by the administrator and/or designee beginning on 8-12-2021 on the process of identifying, preventing, and reporting abuse as well as identifying and implementing immediate interventions for wandering residents. b) Beginning 11/24/2021 the CMS Hand in hand Module 1 -5- 1.Understandig the world of Dementia:the person and the disease 2.Being with a person with Dementia: Listening and Speaking 3. Being with a person with Dementia: Actions and reactions 4.Being with a person with Dementia::Making a difference 5. Preventing and responding to abuse has been added to all staff□s electronic training system and to the new hire	

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{F 600}	Continued From page 111 Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing. A second acceptable allegation of compliance was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 09/26/2021. The State Survey Agency determined the Immediate Jeopardy was removed as alleged during a revisit conducted on 09/28-30/2021, which lowered the scope and severity to "D" 42 CFR 483.10 Resident Rights (F580), 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686), 42 CFR 483.35 Nursing Services (F725), and 42 CFR 483.45 Pharmacy Services (F755); and to "E" at 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.25 Quality of Care (F692), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867), and 42 CFR 483.80 Infection Control (F880), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's "Abuse Prohibition/Investigative" Policy, last revised in November 2016, revealed the facility would prohibit abuse/neglect. Per the policy, the facility would ensure it was doing all, that was within its control to prevent occurrences of abuse and neglect. According to the policy, abuse was	{F 600}	training requirement. The training will be required for all Parkview staff annually. All staff will complete all 5 modules by 12/30/2022. The DON/ designee will monitor completion. New hires will complete modules 1-5 in the first 90 days of hire. c) By 11/30/2021 all staff will take a re- test on recognizing abuse and reporting abuse which will be graded by the NHA/DON or designee to establish staff competency. Staff not working will take the quiz on their next scheduled shift. Staff (including agency and new hires), who do not pass the test with a 100% will be-re-educated and re-take the test until a score of 100% is achieved. Criteria 4: a) During the Ad-hoc QAPI meeting on 08-12-2021, the Abuse/Neglect policy, wandering identification and intervention process was reviewed, and audits put in place to ensure compliance with this process. b) On 8-13-21 the administrator and/or designee began an employee verbal staff quiz, 5 employees per week were questioned on identifying signs/symptoms of abuse, when to report abuse, signs/symptoms of wandering residents and interventions appropriate for wandering residents weekly. Audits will continue weekly and will be reviewed at QAPI monthly and will continue until substantial compliance is achieved. c) Beginning 09-01/2021 the Director of Nursing or designee will review each resident's wandering risk assessment upon admission and readmission.	

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{F 600}	Continued From page 112 defined as the willful infliction of injury, and deprivation by an individual, which included a caretaker, of goods or services which were necessary to attain or maintain physical, mental and psychosocial well-being. The policy also stated verbal abuse was the use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend or disability. Sexual abuse was defined in the policy as non-consensual sexual contact of any type with a resident and neglect was defined as the facility's failure to provide goods and services to a resident, which were necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy also stated the facility would take actions to prevent abuse in the facility which included identifying, correcting and intervening in situations in which abuse was more likely to occur and developing a care plan that identified appropriate interventions to prevent occurrences of abuse. Examples of abuse, per the policy, included incidents of resident to resident abuse and suspicious bruising, and any injury of unknown origin. The policy also stated the Administrator was responsible for implementation of the policies/procedures which prohibit abuse and neglect in the facility. Review of the facility's Brief Interview for Mental Status (BIMS) list for facility residents indicated Resident #322 was interviewable with a BIMS score of twelve (12) and Resident #86 was also interviewable with a BIMS score was ten (10). The list also indicated Resident #64's BIMS score was eight (8). Review of the medical record revealed the facility	{F 600}	Residents identified as a risk for wandering will be brought to the clinical morning meeting for review and initiation of new interventions. Any variance or identified concerns will be addressed immediately. New interventions will be care planned in the morning meeting by the Director of Nursing, Assistant Director of Nursing or nursing designee weekly x4 then monthly x2. Audits will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance d) Starting 7-26-2021 the Social Services Director or designee began performing random interviews of 10 residents a week for 4 weeks the 5 residents a week for 8 weeks of residents with a BIMS score of 8 or greater to ensure they feel safe in the facility and have not witnessed or been subjected to abuse. Audits of a minimum of 5 residents a week will continue until compliance is achieved. Any reports of abuse will be immediately reported to the Administrator with initiation of the investigation. Audits will continue weekly and will be reviewed at QAPI monthly x 3 moths and then quarterly until in substantial compliance. e) Beginning 11-1-2021 resident to resident incidents will be audited weekly to ensure interventions have been put in place to protect resident safety and are care planned. Audit will continue weekly and will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance. f) Beginning 11-22-21 DON or designee will review random weekly skin assessments for residents with a BIMS	

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{F 600}	Continued From page 113 admitted Resident #82 on 05/12/2021 with diagnoses, which included Unspecified Dementia with behavioral disturbances and Parkinson's Disease. Review of Resident 82's Quarterly Minimum Data Set (MDS) assessment, dated 07/14/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of zero (00) out of fifteen (15), indicating the resident was not interviewable. According to the MDS, Resident #82 had physical behaviors directed towards others, rejected care and wandered, one (1) to three (3) days during the assessment period. Resident #82's MDS also revealed he/she required extensive assistance of one (1) staff member when transferred between surfaces and walking. Review of Resident #82's Comprehensive Care Plan revealed on 05/20/2021, staff identified the resident had behavior symptoms that were not easily directed such as: wandering, agitation and the resident was also physically/verbally abusive to others. Review of Resident #82's care plan also revealed he/she wandered into other residents rooms and sometimes urinated. Further review of the care plan revealed interventions developed on 05/20/2021 included to approach the resident calmly/quietly, attempt to discover reason for behavior such as pain, wants, needs or toileting, administer medications and review medications as needed, psychiatric consults and send to hospital as needed. Further review revealed even though Resident #82 exhibited ongoing behaviors in the facility, the only time staff reviewed/revised his/her care plan was on 07/14/2021, when interventions were added for staff to check for toileting needs, thirsts and	{F 600}	score of less than 8 to ensure there are no injuries of unknown origin. 5 random residents will be audited weekly until substantial compliance, then monthly x 2. Any variance or identified concerns will be addressed immediately. Audits will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance g) Beginning 12/3 /2021 a member of the governing body is on site daily. The governing body member will review the resident interviews to ensure that any interviews indicating abuse or neglect has been investigated and reported as required. Criteria 5: Date of compliance: 12/30/2021	

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{F 600}	Continued From page 114 hunger. Observations conducted of Resident #82, on 07/27/2021 at 12:20 PM and at 4:20 PM, revealed the resident was wandering in the facility hallways going in/out of other resident's rooms. 1. Review of an incident report dated 05/18/2021 at 8:02 AM, revealed Resident #322 reported to staff another resident wandered into his/her bathroom while he/she was "in there". Further review revealed when Resident #322 attempted to remove the other resident, he/she "grabbed" Resident #322's arm which resulted in a 1 centimeter (cm) x 1 cm skin tear to his/her arm. Review of Resident #82's medical record revealed no documented evidence of the incident reported on 05/18/2021. Interview with Resident #322, on 07/27/2021 at approximately 12:30 PM, revealed he/she was afraid of Resident #82. According to the resident, "a while back" Resident #82 entered his/her bathroom while he/she was toileting and when he/she attempted to remove Resident #82 from his/her bathroom, Resident #82 grabbed Resident #322's arm and "ripped" the residents skin. Resident #322 stated he/she had reported to staff he/she was afraid of Resident #82 Continued interview revealed Resident #82 had also exposed him/herself to Resident #322 and had tried to get in the bed with the resident on multiple occasions. However, he/she stated nothing had been done to protect the resident and Resident #82 still wandered in/out of his/her room. Interview with Registered Nurse (RN) # 1, on	{F 600}		

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{F 600}	Continued From page 115 07/30/2021 at 9:50 AM, revealed she completed the incident report for Resident #322 when the resident reported to her Resident #82 wandered into his/her bathroom. The resident reported he/she attempted to remove Resident #82 from his/her bathroom the resident grabbed his/her arm and caused a skin tear. The RN acknowledged the incident was resident to resident abuse and stated she reported the incident immediately to the Assistant Director of Nursing (ADON). However, the ADON failed to direct staff to take any actions to prevent any further incidents of resident to resident abuse concerning Resident #82. RN #1 stated Resident #82 has continued to wander in/out of Resident #322's room, as well as other residents rooms and also stated Resident #322, Resident #64 and Resident #86 verbalized to her that they were fearful of Resident #82. Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing, on 08/11/2021 at 12:00 PM, revealed she initially stated in interview she was not aware Resident #82 exhibited abusive behaviors towards other residents in the facility. However, when asked about the incident that occurred on 05/18/2021 with Resident #322, she was able to recall the incident and acknowledged staff reported the incident to her. The ADON stated the incident was an allegation of resident to resident abuse and interventions should have been implemented to protect residents from abuse; however, she stated no action was taken. Per the ADON, she reported the incident to the Administrator at the time the incident occurred, but was unsure if he had reported it to State Agencies or not and he was no longer employed at the facility. According to the ADON, she was not responsible to report	{F 600}		

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{F 600}	Continued From page 116 abuse allegations to State Agencies; however she was responsible to investigate allegations of abuse, but had not investigated this incident because she was not directed to do so. 2. Continued review of Resident #82's medical record revealed on 05/21/2021 at 10:20 AM and on 05/22/2021 at 3:29 AM, the resident continued to wander in/out of other resident's rooms and was "becoming verbally abusive with other residents." Interview with RN # 1, on 07/30/2021 at 9:50 AM, revealed she made an entry in Resident #82's medical record on 05/21/2021 regarding the resident being verbally abusive with other residents. She stated the resident was wandering in other resident rooms and would "yell and argue back" with the other residents, as they were asking Resident #82 to exit their personal space. She could not recall which residents were involved "that was a while back" but stated, she had not filled out an incident report. The RN stated she reported the abuse incidents to "someone but don't remember who;" however, stated she was not directed to take any actions to prevent further abuse from occurring. Interview with RN # 9, on 07/29/2021 at 9:30 PM, revealed she documented Resident #82's behaviors on 05/22/2021 regarding the resident's abuse towards other residents, which had been ongoing since he/she was admitted at the facility and Administrative staff have taken no action to his/her behaviors. Continued interview revealed Resident #82 wandered into other residents personal space "constantly" and was difficult to redirect. She stated he/she would go into others rooms, go through their personal belongings and	{F 600}		

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{F 600}	Continued From page 117 when residents got upset due to this behavior, and ask him/her to leave their rooms, Resident #82 "yells and makes growling noises and scares the other residents." According to the RN, she had not filled out incident reports related to the witnessed events, but the incidents were reported to the previous Administrator, the current ADON and the Administrator "too many times to count"; however, nothing had been done to prevent further abuse from occurring. Review of Resident #82's medical record revealed, on 06/02/2021, he/she was evaluated by the facility Psychiatry services for the first time since admission. Review of documentation indicated the resident's initial complaints were behaviors and confusion and the findings indicated the resident was "compliant with current treatment" and recommendations were made to monitor/document any associated side effects, evidence of psychosis and/or changes in mental status, mood, behavior, sleep, or appetite. 3. Review of Resident #82's facility reported incident, dated 06/04/2021, revealed at 1:15 PM RN #1 heard a noise coming from the hallway and when staff evaluated where the noise was coming from, Resident #82 was found in Resident #64's room "holding onto" Resident #64's wrist and arm and would not let go. Review of the incident revealed staff "had to remove" Resident #82's hand from Resident #64's arm and physically assist Resident #82 from Resident #64's room because the resident was not able to be verbally redirected. According to the facility reported incident, Resident #82 was transferred to the hospital for an "overnight" evaluation on 06/04/2021 and when the resident returned from the hospital the following day, Resident #82 was	{F 600}		

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{F 600}	Continued From page 118 placed on an increased level of supervision; every fifteen (15) minute checks for seven (7) hours, every thirty (30) minutes for twelve (12) hours, and every hour for twelve (12) hours (totaling approximately thirty-one (31) hours), and a stop sign was placed over Resident #64's door and the facility psychiatrist was ordered to evaluate Resident #82's behaviors. Review of Resident #82's medical record revealed on 06/04/2021 at 1:10 PM, staff heard someone "yelling" and when staff "went to check and see what was wrong" one resident was observed in another residents room and he/she had his/her "hand wrapped around" the other residents right forearm and wrist. Continued review of the record revealed the resident (no resident specified) "would not lessen grip" and "staff had to remove" his/her hand and assist the resident back to his/her room. The record also revealed the resident was transferred to the hospital on 06/04/2021 at 2:10 PM. Review of Resident #82's medical record revealed the resident returned to the facility on 06/05/2021 at 6:30 AM. Even though the resident was to be on an increased level of supervision, review of the nurses notes revealed he/she continued to wander in/out of other resident's rooms and was difficult to redirect. Further review of the record revealed at 8:30 AM on 06/05/2021, Resident #82 was "walking in front of other residents and trying to grab them both male and female" and the resident continued to wander into other residents rooms and "they start yelling and screaming." Continued review of Resident #82's medical record revealed the resident continued to wander in/out of other residents rooms on 06/07/20 21 and again on 06/10/2021.	{F 600}		

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(F 600)	Continued From page 119 Interview with Resident #64, on 07/27/2021 at 12:45 PM, revealed he/she had been abused by Resident #82 and he/she was afraid of the resident, and had reported his/her fear to facility staff. However, the resident stated nothing was done to protect him/her and even though Resident #82 wandered into his/her room and "grabbed my arm and wouldn't let go". The resident stated Resident #82 continued to wander in/out of his/her room at times, and "no one does anything to stop" him/her from coming "in here on me again." Review of Resident #82's medical record revealed he/she was evaluated by the facility psychiatric services again, on 06/14/202,1 and his/her chief complaints were wandering/inappropriate behaviors, the resident was hard to redirect, talked to him/herself and had a history of violence towards others. According to the evaluation, the resident's family reported he/she had a history of violence and staff reported the resident would become "wild as a buck," was hard to redirect and he/she went into other resident rooms and residents were "uncomfortable" around Resident #82. Documentation also indicated the residents treatment recommendations was "psychiatric medication management." However, no medication changes were recommended during the evaluation. Interview with Registered Nurse (RN) # 1, on 07/30/2021 at 9:50 AM, revealed she was working when the incident occurred with Resident #64 on 06/04/2021 and she notified the Administrator. She stated even though the resident was transferred to the hospital and	(F 600)		

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(F 600)	Continued From page 120 returned the following day, his/her behaviors continued. The RN stated, Resident #64 reported he/she was afraid of Resident #82; however, the resident continued to wander in/out of other resident's rooms and no actions had been taken to protect the residents. Review of facility reportable incidents indicated the facility reported the incident that occurred on 06/04/2021 which involved Resident #82 and Resident #64. According to the reported incident, RN #1 heard a noise coming from the hallway and when the nurse went to investigate she found Resident #82 in Resident #64's room and the resident had hold of Resident #64's wrist and arm and would not let go. Staff intervened and removed Resident #82 from his/her room and he/she was sent to the hospital for an overnight evaluation and returned to the facility on 06/05/2021. Further review of the facility reported incident, dated 06/04/2021, revealed the facility did "substantiate the allegations" that Resident #82 "did in fact hold on to" Resident #64's wrist, was not able to be redirected which resulted in "non-injury to resident" #64. The facility recommended psychiatric services to evaluate the resident's behaviors. The report failed to indicate if abuse was substantiated or not. 4. Review of a facility reported incident revealed on 06/30/2021 Resident #82 wandered into Resident #317's room. Resident #317 was asking the resident to leave his/her room and Resident #317 was "holding onto" Resident #82's wrist. Staff escorted Resident #82 out of his/her room. According to the facility reported incident, the facility determined they did not substantiate	(F 600)		

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{F 600}	Continued From page 121 abuse between Resident #82 and Resident #317. Continued review of the report revealed due to "medical condition of Dementia and Alzheimer's Disease" Resident #82 "inadvertently entered room, looking for" his/her room and he/she was transferred to the hospital for evaluation and treatment. Review of Resident #82's medical record revealed the resident was transferred to an inpatient psychiatric stay on 07/01/2021 and returned to the facility on 07/08/2021; however, according to staff there were no changes in Resident #82's behaviors when he/she returned from the hospital stay. 5. Review of Resident #86's medical record revealed, on 07/13/2021 at 11:15 AM, Resident #86 called the State Police because Resident #82 was coming in his/her room and was exposing him/herself. However, review of the record revealed RN #1 informed the Police that "95% of our residents had Dementia and some do wander". Per the record, the RN informed the Police a resident had not been exposing him/herself to Resident #86 or others. The RN also documented she informed the Police Resident #86 "has been known to exaggerate." Interview with Registered Nurse (RN) # 1, on 07/30/2021 at 9:50 AM, revealed she was working on 07/13/2021, when Resident #86 contacted the State Police. The nurse stated the incident were reported to the Administrator; however, no actions had been taken to protect the resident or to investigate the resident's allegation. She stated she informed the police the incident had not occurred because she had not witnessed it; however, acknowledged the	{F 600}		

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{F 600}	Continued From page 122 incident was an allegation of abuse which should have been reported/investigated and interventions should have been implemented to protect the resident. 6. Review of Resident #86's facility reported incident, dated 07/15/2021, revealed Resident #82 wandered into Resident #86's room and "picked up" Resident #86's shoes and then turned to leave the residents room. According to the incident report, Resident #86 pressed his/her personal alarm provided by the facility and threw water on Resident #82. Documentation on the report also indicated a stop sign had been implemented to prevent residents from wandering into his/her room, however Resident #86 "frequently takes it down." Continued review of the investigation revealed the facility determined Resident #82 was abused by Resident #86, and the report also stated steps taken to prevent further abuse was that the facility would encourage Resident #86 to keep his/her stop sign up when he/she was in her room. Review of Resident #86's medical record, dated 07/15/2021, revealed at approximately 5:50 PM Resident #82 had wandered into Resident #86's room and "picked up" the residents shoes. According to the record Resident #86 informed staff that he/she was asleep and when the resident woke up, the other resident was in her room and the resident stated "I was afraid" he/she was going to hit me so I threw water on" him/her and also informed staff he/she "would get" him/her "before" he/she "gets me." The medical record also revealed Resident #86 informed staff his/her stop sign was not in use at the time of the incident, and he/she stated he/she preferred not to utilize the stop sign.	{F 600}		

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{F 600}	Continued From page 123 Observations conducted of Resident #86, on 07/27/2021 at 1:00 PM, revealed no stop sign was in place and no personal alarm was in use on the resident's person, to prevent other residents from entering his/her room. Further observations revealed a large bruise, approximately 6 x 8 inches in size, and red/purple in color to the resident's left upper arm. The resident informed the surveyor he/she sustained the bruising when Resident #82 hit him/her with a shoe. An interview with Resident #86, on 07/27/2021 at approximately 1:00 PM, revealed he/she felt like the facility was not trying to help him/her, and the resident did not know what else to do. The resident stated Resident #82 entered his/her room, "beat me up" and then "asked me how I liked it". Per the resident, Resident #82 had exposed him/herself to the resident numerous times since Resident #82's admission to the facility. The resident stated he/she reported the incidents to facility staff; however, no one here is helping me. Resident #86 stated he/she had even contacted the Police, but again, "no one has done anything" to help the resident. The resident also stated he/she was "moved down here" (to the opposite end of the hall) to keep Resident #82 away from him/her; however, Resident #82 continues to come in/out of his/her room, even after he/she was hit by the resident. Resident #86 stated, on 07/15/2021, he/she was lying in his/her bed and Resident #82 entered his/her room again, exposed him/herself to the resident and picked up the residents shoe and hit him/her, with the shoe on the left upper arm. The resident stated he/she threw water on the resident to get him/her out of his/her room, and he/she reported	{F 600}		

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{F 600}	Continued From page 124 to staff that Resident #82 exposed him/herself to him/her again; however, no actions have been taken to protect him/her from further abuse from Resident #82. Interview with State Registered Nurse Aide (SRNA) #16, on 07/27/2021 at 8:10 PM, revealed she cared for Resident #82 since he/she has been admitted to the facility and he/she wandered into other residents rooms, "picks up their" personal belongings and exposes him/herself to other residents. The SRNA stated Resident #82 had been exposing him/herself to Resident # 86 for "a long time." She stated the concern had been reported to RN #9 and the RN had contacted the facility Administrator; however, staff were instructed to move Resident #86's room when he/she "hadn't done anything wrong," because the residents resided across the hall from each other when the incident occurred, sometime in "early June" 2021. According to the SRNA, even though the resident's room had been moved, Resident #82 continued to wander in/out the resident's room, and continued to expose him/herself to the resident. SRNA #16 stated incidents continued to be reported to nursing staff, which informed the SRNA they had reported to ongoing concerns to the Administrator; however, no actions had been taken to protect Resident #86 or others from abuse. The SRNA stated she worked the night shift (6 PM-6 AM) beginning on 07/15/2021 after the incident occurred between Resident #82 and Resident #86. She stated upon her initial rounds at approximately 6.30 PM, Resident #86 reported the incident and stated Resident #82 came in his/her room, exposed him/herself to the resident again and hit him/her with a shoe. The SRNA also stated, Resident #86 had a "large purple	{F 600}		

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{F 600}	Continued From page 125	{F 600}		

bruise" to his/her left arm at the beginning of his/her shift, and she reported the resident's injury to Licensed Practical Nurse (LPN) #8. She stated the Administrator was on the unit after the incident occurred; however, she had not been questioned about the incident until questioned by the surveyor. According to the SRNA, Resident #82 continued to wander in/out of other resident's rooms and no actions were taken to protect residents from abuse.

Interview with SRNA #18, on 07/27/2021 at 10:00 PM, revealed he/she also worked the night shift on 07/15/2021 and observed a large bruise and a "knot" to Resident #86's left upper arm. The SRNA stated Resident #86 reported that Resident #82 entered his/her room, exposed him/herself to the resident and hit the resident with a shoe. The SRNA stated Resident #82 frequently wandered into other resident's rooms, and Resident #86 had reported, on numerous occasions Resident #82 exposed him/herself to the resident and wandered in/out of his/her room; however, no actions were taken to protect the resident. The SRNA stated he/she could not understand why Administration "punished" and "acted like it was" Resident #86's fault, especially since this was not the first time the resident had exposed him/herself to Resident #86. According to the SRNA, the resident's large bruise and "knot" was reported to LPN #8.

Interview with LPN #8, on 07/27/2021 at 9:30 PM, revealed she worked the night shift (6 PM-6 AM) on 07/15/2021 when the incident occurred, and also stated the incident occurred right before she arrived for her shift. She acknowledged Resident #86 informed staff Resident #82 entered his/her room, exposed him/herself to the resident, and hit

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{F 600}	Continued From page 126	{F 600}		

the resident with a shoe. She also stated staff reported a large bruise on Resident #86, which she observed and reported the bruising to the ADON; however, the ADON failed to implement any interventions to protect residents from abuse.

Interview with the ADON/Interim Director of Nursing, on 08/11/2021 at 12:00 PM, she was aware Resident #86 was afraid of Resident #82; however, stated she thought the resident was just "afraid in general in the facility" and felt like his/her fear was unrelated to Resident #82, and he/she "just didn't like" Resident #82. She also stated she came to the unit, on 07/15/2021, when Resident #82, wandered into Resident #86's room; however, stated no one informed her Resident #86 reported to staff Resident #82 exposed him/herself to the resident that day, or any other day. She also stated staff had notified her of a bruise on Resident #86's left arm; however, stated she felt the residents bruise was self-inflicted because someone told her Resident #86 had been observed "poking at" his/her arm.

7. Review of Resident #64's record revealed Resident #82 entered his/her room again on 07/31/2021 at approximately 4:50 AM, was going through the residents personal belongings and when Resident #64 asked Resident #82 to exit his/her room, Resident #82 hit Resident #64 on the right wrist. According to the record, a small red area was observed to his/her right wrist.

Interview with RN #9, on 07/29/2021 at 9:30 PM, and again on 08/02/2021 at 2:00 PM, revealed she provided cared to Resident #82 since he/she was admitted to the facility in May 2021, and his/her abusive behavior towards staff and other residents had been continuous since admission.

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{F 600}	Continued From page 127 The RN stated Resident #82 had wandered in/out of other resident's rooms, "yelled/growled" at other residents and created fear in others. She also stated Resident #64, Resident #322 and Resident #86 had reported they were afraid of Resident #82 and even though the concerns have been reported to the ADON and the Administrator, on more than one occasion, no actions have been taken to protect the residents. However, the RN stated sometime in June 2021, exact date unknown, a SRNA reported to her that Resident #86 informed staff that Resident #82 exposed him/herself to the resident. According to the RN, she reported the resident's allegation to the Administrator and the Administrator instructed the RN to move Resident #86 to the other end of the hall, because the residents resided across the hall from each other. She stated Resident #86 was moved as directed by the Administrator; however, Resident #82 continued to wander down the hall, into his/her room and expose him/herself and has also hit Resident #86 with a shoe, resulting in a large bruise and a hematoma since he/she had been moved. According to the RN, Resident #82 wandered into Resident #64's room and hit the resident again on 07/31/2021. She stated Resident #64 was already afraid of the resident because he/she had previously hit the resident, and when she assessed Resident #64 on 07/31/2021 after the incident occurred, the resident was "in tears." The 07/31/2021 incident was reported to the Administrator, and the RN was instructed to keep the resident a 1:1; however, the RN stated she informed the Administrator due to staffing, that was not possible, and no further direction was taken to protect the residents. Review of nursing documentation, on 08/01/2021	{F 600}		

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{F 600}	Continued From page 128 at 3:15 PM, Resident #82 was alert, and "wandering into rooms," approximately 10 hours after he/she hit Resident #64 for the second time. Interview with the ADON/Interim Director of Nursing, on 08/11/2021 at 12:00 PM, she had worked at the facility for approximately one (1) year and had just been moved into the position of interim DON within the last few weeks. She also stated since being ADON at the facility, she had worked the floor as a staff nurse, more than she had been able to conduct morning meetings, or complete any monitoring in the facility for the residents. She also stated the facility had no system in place to monitor resident behaviors which could result in resident to resident abuse incidents; however, stated residents should be free from abuse in the facility and should not be afraid. Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she was the Abuse Coordinator and was aware Resident #86 informed staff he/she was afraid of Resident #82. However, the Administrator stated she felt Resident #86 targeted Resident #82 and also stated she thought Resident #86 "hit" his/her self and stated she felt the residents bruising was self-inflicted. When asked what interventions she had implemented to ensure Resident #86 was free from abuse in the facility, she stated she had provided the resident with a personal alarm to ring when incidents occurred, and had staff place a stop sign at his/her door; however, the resident refused to utilize the interventions and stated nothing else had been implemented to protect the resident or to help him/her feel safe in the facility. She acknowledged however, Resident #82's wandering into other residents rooms did trigger	{F 600}		

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{F 600}	Continued From page 129 resident to resident abuse incidents, and when asked what interventions had been implemented to protect other residents from abuse, as well as Resident #82 she stated, "I can attempt to place" him/her somewhere else because he/she wanders. She also stated she had no system in place to monitor resident's behaviors in the facility because thiswas a "nursing thing." She also stated meetings were being held Monday-Friday to discuss nursing issues; however, she was not sure who attended those meetings. Per interview the ADON frequently worked the floor as a staff nurse due to short staffing in the facility. Further she stated she had not attended any of those meetings since she became Administrator on 06/07/2021 because "this place is such a mess" and she had "a lot of issues in the facility kitchen." **The facility alleged the following was implemented to remove Immediate Jeopardy effective 09/26/2021: 1). Braden Scale Assessments were completed on all residents by facility nurses on 08/28/2021 and comprehensive full body skin assessments were completed on all residents on 09/11/2021. The facility utilized the Braden Scale Assessment and comprehensive full body skin assessment to review and update care plans of residents who had pressure injuries by 09/17/2021. 2). The wound care physician evaluated Resident #65 on 08/25/2021. Staff assessed and measured all pressure injuries, and staff evaluated all current treatments and reported them to the Medical Director/Physician #1 by 09/17/2021. 3). Beginning 09/17/2021, upon admission a skin	{F 600}		

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{F 600}	Continued From page 130 assessment and Braden Scale assessment will be completed, and the baseline care plan will be developed within 48 hours to include any pressure ulcer or potential for pressure ulcer. A comprehensive care plan will be developed within 21 days of admission to include pressure ulcers or potential pressure ulcers and include interventions to prevent pressure ulcer development or worsening of pressure ulcers. 4). Residents #45, #65, #308, #309, #311, #314 and #320 were bathed including a shower, nail care and moisturizing lotion applied post shower, and assisted with dressing in clean appropriate clothing. Clean linens were placed on the residents' beds on 09/11/2021. The residents were evaluated by social services on 09/15/2021. 5). All residents were offered a shower and interviewed to obtain shower/hygiene preferences by the Director of Nursing (DON) or designee. New bath/shower schedules were implemented by nursing staff to accommodate resident preference. Resident preferences for hygiene were obtained and incorporated into resident care plans and State Registered Nurse Aide (SRNA) care plans by the Regional Nurse Consultant were completed on 09/13/2021. 6). On 08/28/2021, the Registered Dietitian (RD) began reviewing all residents' diets and made recommendations for meal changes or supplements to promote healing and to address any weight loss issues. 7). All residents with the diagnoses of Diabetes and Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by licensed nurse and/or Respiratory Therapist	{F 600}		

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{F 600}	Continued From page 131 with no concerns were identified completed 08/13/2021. 8). The Regional Nurse reviewed all residents with orders for glucose monitoring by 07/30/2021 and orders were amended to include mandatory entry of glucose values on the Medication Administration Record (MAR). 9). The Regional Certified Dietary Manager (CDM) observed the meal service for breakfast, lunch and dinner on 09/11/2021, all three meals were delivered on time. 10). Direct Care staffing was increased through recruitment efforts with additional staffing provided through agency and travel contracts. Direct care nursing staff schedules for the next day will be reviewed daily by the Director of Nursing and the Administrator to ensure staffing levels are adequate to meet the acuity of the residents. The staff will be validated as present on the unit at the start of each shift by the Director of Nursing, Nursing Supervisor, Administrator or designee. Direct care nursing staff call offs will be replaced by calling other qualified staff to see if they can fill the opening, and/or calling agencies to see if they have qualified staff to fill the opening. If direct care staff cannot be replaced the Director of Nursing, Assistant Director of Nursing, or member of the nursing management team will fill the shift. If appropriate staffing levels cannot be met, the center will prioritize resident care that can be achieved during emergency staffing, prioritize required task including administration of medication, no showers- sponge baths, care provided to incontinent residents, turn residents that cannot turn self, meals served timely, and	{F 600}		

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{F 600}	Continued From page 132 assist residents with meal if needed. 11). The facility has increased dietary staffing through recruitment efforts and appropriate staffing levels have been achieved to ensure meals are prepared and delivered timely. 12). On 08/11/2021, all residents including #64, #86 and #322, were reassessed for psychosocial and physical forms of abuse with Brief Interview for Mental Status (BIMS) score of eight (8) or above and skin integrity reviews for residents with BIMS less than eight (8) were completed by Licensed Nurse. Residents with a diagnosis of Dementia had their Care Plan reviewed and revised, as necessary by the Minimum Data Set (MDS) Coordinator on 09/07/2021. No new residents were identified as indicating any psychosocial and/or physical harm. 13). The Regional Nurse Consultant completed a wandering risk assessment on all residents by 08/16/2021. All residents who were identified as at risk for wandering had care plans reviewed and updated by the MDS Coordinator. A list of all identified active wander risk residents were placed at each nursing station with a list of potential interventions for nursing to reference. 14). Residents #39, #65, #81, #90, #330 and #332 were weighed by 09/17/2021. The Registered Dietician (RD) completed a comprehensive nutrition assessment and RD recommendations were reviewed for recommendations by the Director of Nursing (DON) or designee on 09/17/2021. Further, the DON or designee, spoke with the attending Medical Doctor (MD) and validated the diet orders and recommendations. Recommendations were	{F 600}		

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{F 600}	Continued From page 133 entered into the electronic medical record and on the tray card. The Registered Dietician and Director of Nursing (DON), reviewed diet orders in electronic medical record to ensure both the record and tray card reflected accurate information on 09/17/2021. 15). Beginning 09/15/2021, staff began offering snacks to all residents daily in the morning and afternoon by the restorative nurse aide, activity aides, or designee. Snacks ordered by a physician will be documented by the restorative aide, dietary aides and/or licensed nursing staff. 16). The facility evaluated the COVID-19 unit on 08/11/2021, located on the 5th floor of the facility for compliance with CDC guidelines and implemented yellow and red zones. The DON identified two (2) residents who had been exposed to positive residents and a yellow zone was designated with erection of a plastic zip wall barrier and those two (2) residents were moved to this zone on 08/11/2021. 17). The facility had three (3) residents who were in the red zone on 08/11/2021(Residents #327, #328 and #329). Residents #327, #328 and #329 have completed quarantine per facility policy and physician orders. Residents #311 and #314 completed quarantine per COVID-19 policy and physician's order. Residents #311 and #314 were no longer in isolation. 18). All staff eligible for testing were tested for COVID-19 on 09/16/2021. The facility did not identify any new cases based on the employee testing on 09/16/2021. All residents eligible were tested for COVID-19 on 09/17/2021. The facility did not identify any new positive cases.	{F 600}		

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{F 600}	Continued From page 134 19). The facility was conducting ongoing surveillance testing as recommended for COVID-19. Positive COVID-19 residents will be placed in isolation zone (red zone) and placed in droplet precautions with use of personal protective equipment. The facility will provide physician notification, family notification and care plan revisions. The DON or designee will review newly positive COVID-19 residents to ensure isolation precautions have been initiated. In addition, any resident exposed will be placed in droplet precaution in isolation zone (yellow). The facility will provide physician notification, family notification and care plan revisions. The facility employee testing protocol will be twice weekly on designated days effective 08/16/2021. The facility requires all staff must be tested on designated days. If the employee is not tested, the facility will not allow the employee to work without a current negative COVID-19 test. During testing, the employee will be tested prior to entering the facility by the Infection Prevention Nurse or designee. All testing dates and times will be posted to the employee page, time clock and common areas. 20). The facility screens all residents once a shift for signs and/or symptoms of COVID-19 and documented on the Medication Administration Record (MAR). The facility implemented monitoring for signs and/or symptoms on all residents on 09/17/2021. 21). Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351, medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021.	{F 600}		

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{F 600}	Continued From page 135 22). The facility stated all residents will receive their medication as ordered beginning 09/23/2021 and implemented pharmacy and physician notification if any medication was unavailable. The facility will abide by new orders from the physician regarding the unavailable medication. 23). The facility formulated an agreement on 09/23/2021, with the facility's pharmacy to provide the facility with a three (3) day supply of medications that requires the facility's approval for cost authorization while pending cost review. 24). New admissions and re-admissions entering the facility after normal business hours and on weekends will have discharge orders submitted, entered into the electronic medical record and submitted to pharmacy through pharmacy integration. The facility implemented the use of fax transmittal as a backup to the electronic pharmacy integration by entering the order in the electronic medical record to receive medications. If the facility does not receive medications in a timely manner the pharmacy will be notified, and the facility will utilize the emergency medication kit. If an emergency arises and medication is unavailable, the physician will be notified for substitution and/or new orders. 25). The Regional Nurse Consultant, Director of Nursing, and licensed nursing staff completed an audit of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. 26). The facility conducted a Quality Assurance Performance Improvement (QAPI) meeting on 08/12/2021. The facility reviewed education,	{F 600}		

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{F 600}	Continued From page 136 facility process, and audited implementation to ensure compliance with the AOC and all audits. The Administrator oversees the QAPI committee. The QAPI committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 27). The facility appointed an Interim Administrator on 09/13/2021 to replace the current Administrator. The facility's Interim Administrator will receive daily oversight and guidance from the Regional Vice President or Regional Director of Operations and Regional Clinical Nurse for 30 days. Upon completion of the thirty-day oversight, the Regional Administrative Team will audit the Administrator to determine if continued daily oversight is needed. The administration has direct oversight and responsibility to direct, discipline, and communicate areas of concern and process improvement. 28). The Administrator, Medical Director, and QAPI Committee reviewed procedures for a contact person for call-ins, answering call lights, Activities of Daily Living (ADL) Care, serving, and timeliness of meal trays incontinence care and turning and repositioning on 09/15/2021. 29). The Vice President of Operations, Director of Clinical Operations and Regional Nurse Consultants conducted a conference call on 09/15/2021 with a contract company for a consultation to review the following: (1) the outcomes of the survey; (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations; (3) determined a plan for	{F 600}		

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{F 600}	Continued From page 137 the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). The Administrator and Regional Nurse Consultant reviewed and revised the QAPI Plan beginning 09/16/2021 and presented the reviews and/or revisions to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The agenda included reviewing pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, hospital readmission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns, grievances, admissions, discharges, census, staff development, vacant positions, employee orientation, dietary variances, tray audit report, weight loss, work injuries, terminations, employees on family medical leave, a leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include, but not limited to, the topics presented during the meeting. 31). The Regional Director of Operations and	{F 600}		

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{F 600}	Continued From page 138 Vice President of Operations met with the Administrator, the DON, and the Medical Director on 09/16/2021 regarding the duties of the Governing Body, including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes with the utilization of the five (5) why approaches and, auditing systems per the QAPI Calendar. The Administrator will notify the medical Director of future QAPI Committee meetings. 32). The Administrator will collect all monitoring reports before each QAPI Committee meeting beginning 09/15/2021 for review to ensure compliance with the deficiencies cited during the 09/10/2021 survey. QAPI Meetings were held on 09/16/2021 to discuss abatement and develop interventions to remove the jeopardy. The facility implemented QAPI meetings weekly, times four (4) weeks, as needed, and monthly. The Administrator will forward all QAPI Meeting minutes to the Governing Body members, including the Vice President of Operations, Regional Vice President of Operations, and the Regional Nurse Consultant, to review the audit results. The QAPI committee will review the audits at the QAPI meetings. Committee for review. The Administrator oversees the QAPI Committee. The QAPI Committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 33). The Governing Body will provide the facility's	{F 600}		

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{F 600}	Continued From page 139 Administrator with resources and education materials for QAPI, including but not limited to the QAPI Tool Kit, QAPI at a Glance, and a resource guide to effectively implement the QAPI plan beginning 09/16/2021. The Governing Body will meet quarterly for the upcoming year and reevaluate for frequency after one (1) year. 34). The Administrator will increase the frequency of QAPI Committee meetings to weekly for four (4) weeks and, as needed effective 09/16/2021, to ensure the quality of care is monitored and complies with the standard of care and compliance with State and Federal requirements is demonstrated. 35). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. 36). On 09/13/2021, the Regional Certified Dietary Manager (CDM) educated the Dietary Manager on the provision of timely nutritional assessment to ensure diet order accuracy, on diet order accuracy, and on when to enter diet orders into the electronic medical record. The CDM educated the Dietary Manager to enter resident diet orders into the tray care system. If the nurse enters the order, the nurse will send a written communication to the dietary staff, including diet and texture. In the morning clinical meetings, staff will review diet orders from the previous day to ensure accuracy. 37). Therapy provided education to all nursing staff on turning and positioning range of motion,	{F 600}		

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{F 600}	Continued From page 140 and transfer of resident from bed to chair and chair to bed beginning on 08/19/2021 and completed on 09/17/2021. The facility employed and assigned additional staff through recruitment and agency contracts to ensure adequate staff to turn and reposition all residents who cannot reposition themselves. 38). The Regional Director of Nursing educated all nursing staff on pressure ulcer prevention, including turning and repositioning, adequate hydration and nutrition, positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician, and RP of a new skin impairment by 09/17/2021. The facility nursing staff will call or email the Registered Dietitian, Physician, and Resident Representative of any new skin changes. 39). The DON or designee educated all staff on timely call light response. In addition, direct care staff, including nurses and certified nursing assistants, were provided education on providing timely hygiene per the resident's plan of care, timely toileting, dressing residents in their choice of clean clothing, and timely delivery of meal trays. The DON or designee will educate any facility staff not working during education upon returning to work. 40). On 08/31/2021, The Regional Director of Nursing educated all licensed nursing staff, the Registered Dietician, the Social Service Director, and the MDS Nurses on entering new care plans into the electronic medical record, including goals and interventions. In addition, the Regional Director of Nursing educated staff to update the existing care plan in the electronic medical record	{F 600}		

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{F 600}	Continued From page 141 with new goals and interventions for any new skin impairments identified during their shift. 41). The facility's Respiratory Therapist educated Licensed nurses on identifying and assessing residents with a change in respiratory status on 08/12/2021. In addition, on 08/12/2021, the DON and/or designee educated all licensed nurses on identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a resident's change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. The facility licensed nursing staff will not be allowed to work until they have received this education. The DON educated all clinical staff on documentation of glucose levels on 08/19/2021 and 08/20/2021 during mandatory in-services. 42). Beginning 08/12/2021, the DON educated licensed nurses on completing a baseline Care Plan with interventions and goals relevant to diabetes and a respiratory diagnosis within 48 hours of admission, reviewing and providing a copy to the resident and/or the responsible party. Licensed nursing staff not working during education was notified of ongoing education and will not be allowed to work until they have received this education. 43). Beginning 08/12/2021, the DON educated all staff on the facility's "call off" procedure. The call-off procedure for the facility included: in the event a person needs to call out of work for dayshift, they are to notify their immediate supervisor two hours before the start of the shift. If staff needs to call off on the night shift, they are to notify their immediate supervisor four hours	{F 600}		

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{F 600}	Continued From page 142 before the start of their shift. If the facility does not have appropriate staffing levels, the immediate supervisor and/or designee will call other qualified staff to replace the person calling off. If emergency staffing is required, the Administrator and/or designee will call for assistance from staffing companies. Staff not working will be in-serviced upon return to work. 44). All staff were provided re-education by the Administrator and/or designee on 08/12/2021 on the process of identifying, preventing, and reporting abuse, as well as identifying and implementing immediate interventions for wandering residents. 45). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. On 09/13/2021, the CDM educated the Dietary Manager on diet order accuracy and timely nutritional assessment to ensure diet order accuracy. When staff enters diet orders into the electronic medical record, the nurse entering the order will send the written communication to the dietary staff. The Dietary Manager will enter the order into the tray care system. The facility will review diet orders from the previous day in the clinical meeting to ensure accuracy. 46). The Regional CDM educated the Dietary Manager on 09/13/2021 on facility policy regarding meal service times and the use of recipes including recipes for those requiring fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious,	{F 600}		

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{F 600}	Continued From page 143 cultural and ethnic needs of the population. 47). As of 09/15/2021, the Regional CDM completed education with the dietary manager on obtaining food preferences, the facility's tray card system, ordering food based on menus, stocking snack/hydration carts, snacks, and hydrations procedures, appropriate scoop sizes, and/or portion sizes. 48). The Director of Nursing or Regional Director of Nursing educated nurses and the Dietary Manager on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders on 09/17/2021. 49). All staff were provided re-education by the DON and/or designee by 09/17/2021 on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. In addition, the DON/designee educated, licensed staff on monitoring residents for Covid-19 symptoms beginning. 08/12/2021, the DON/designee educated all staff, including contract staff, who were not working. During the QAPI meeting on 08/12/2021, the Covid-19 policy, the handwashing policy, donning and doffing PPE, red and yellow zones, and monitoring residents for signs/symptoms of the Covid-19 were reviewed. 50). Staff were provided re-education on 08/20/2021 by the DON, Regional DON, or Regional Nurse Consultant to enter COVID-19 symptom monitoring orders on all new admissions into the resident's record.	{F 600}		

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{F 600}	Continued From page 144 51). All licensed nursing staff have been educated on the five (5) rights of medication administration, including right medication, right patient, right dose, right time, and right route. The Regional DON/DON/designee educated all licensed nursing staff working on 09/23/2021 on the process to follow when a medication was not available for administration as ordered. The education included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notify the MD if an ordered medication will either be omitted or given outside of the ordered medication time. The education also included following new orders given by the MD, documenting the conversation, and new orders from the MD in the electronic medical record. All other licensed nursing staff will be provided training as scheduled for shifts. 52). On 09/25/2021, the DON /Regional Nurse Consultant educated all licensed nursing staff, including new hires and/or agency staff, on the use of the emergency medication kit, the system in place for ensuring medications are in-house, or notifying the physician for new orders for new or re-admitting residents, including on weekend and after-hours. 53). The Interim Administrator educated all staff on his contact information and role as the Abuse Coordinator from 09/13/2021 through 09/17/2021. In addition, education on staffing schedules and who to notify if unable to work their scheduled shift. 54). The facility will audit weekly resident head-to-toe skin assessments daily, Monday through Friday, for three (3) months effective 09/17/2021 to ensure they have been completed	{F 600}		

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{F 600}	Continued From page 145 weekly on each resident. In addition, the facility will notify the physician, Registered Dietician, and Responsible Party of any new skin impairment and those new interventions have been put in place to prevent decline. 55). Central supply audited all lab supplies for the expiration date on 08/28/2021. Audits will be conducted weekly for all lab supplies for four (4) weeks effective 09/17/2021 and then monthly for three (3) months. 56). The Director of Nursing, Assistant Director of Nursing (ADON), or Nursing Supervisor will audit resident progress notes for daily four (4) weeks effective 09/13/2021, then weekly for one (1) month. Staff will review Progress notes for Saturday and Sunday on Monday. The Nursing Supervisor conducted audits to ensure any new areas of skin impairment identified had a care plan implemented to include new interventions. 57). Beginning on 09/11/2021, the facility's leadership staff and/or designee began visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning. All residents will be visually rounding on once each shift daily for two (2) weeks, fifty percent of the residents each shift for four (4) weeks, and twenty-five percent of residents each shift for four (4) weeks. The facility has two (2) shifts, 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 58). On 09/11/2021, the facility's leadership staff began visual monitoring and timing of call light response times, including the length of time call lights are answered, across all shifts. Leadership staff will conduct ten (10) call light observations each shift for two (2) weeks and then five (5) call	{F 600}		

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{F 600}	Continued From page 146 light observations each shift for eight (8) weeks. 59). On 08/13/2021, the DON and/or Designee began monitoring respiratory assessments and Situation Background Assessment and Recommendation (SBAR) communications for acute change in respiratory status Monday through Friday in the clinical morning meeting. The facility reviewed any acute change in respiratory status for Physician notification and implementation of any physician order. Care Plans were reviewed and updated as needed. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 60). The MDS Nurse, DON, and/or Designee began audits on 09/15/2021 of baseline care plan completion for all new admissions and re-admissions to ensure staff completed the baseline Care Plan within 48 hours of admission. 61). All residents admitted within the last thirty days with a diagnosis of Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Asthma, or current Pneumonia had their baseline Care Plan reviewed and updated as needed by the MDS Nurse(s) and/or designee. New interventions will be added to the care plan in the morning meeting by the DON, ADON, and/or nursing designee. 62). Beginning on 08/19/2021, the MDS Nurse, DON, and/or Designee will monitor new admissions and re-admissions to audit baseline care plans for completion, accuracy, and review with the resident and/or responsible party. Any variance or identified concern was addressed immediately. Audits will be conducted Monday through Friday for all admissions/re-admissions	{F 600}		

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{F 600}	Continued From page 147 to the facility for four (4) weeks, fifty percent of admissions for a week for two (2) weeks, and then ten percent of admissions weekly for four (4) weeks. 63). On 09/11/2021, the Dietary Manager and/or designee began auditing how long it took to pass meal trays to residents after arriving at the unit. All three (3) meals will be observed on all three (3) units daily for two (2) weeks, two (2) meals on all three (3) units daily for two (2) weeks, and one (1) meal on all three (3) units daily for four (4) weeks. 64). On 08/15/2021, the DON and/or Designee began audits of staff's knowledge with a verbal quiz of identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician's orders. Leadership will quiz staff randomly across all shifts; ten (10) staff for one (1) week and five (5) staff a week for four (4) weeks. 65). On 08/13/2021, the DON and/or Designee began monitoring all documented blood sugar results Monday through Friday in the clinical morning meeting. The DON/designee will review any blood sugar results outside of the normal range for MD notification and implementation of any Physician's Orders. Care plans will be reviewed and updated as needed. The DON or designee will complete a visual rounding on diabetic residents across both shifts and all three (3) units to identify any resident with apparent signs and symptoms of hypoglycemia/hyperglycemia to ensure the	{F 600}		

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{F 600}	Continued From page 148 resident was immediately assessed by licensed staff. Any variance or identified concerns will be addressed immediately. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 66). On 08/13/2021, the Administrator and/or designee implemented an employee questionnaire on abuse and identification of residents with wandering behavior to determine the proper reporting of abuse across all shifts and units. The employee questionnaire will be completed for five (5) staff daily for one (1) week, then three (3) times a week for two (2) weeks, and then weekly for four (4) weeks. Any variance or identified concerns will be addressed immediately. 67). Beginning on 08/13/2021, the Director of Nursing and/or designee will review each resident's wandering risk assessment upon admission and quarterly with their Minimum Data Set (MDS) assessment. Any resident identified as wandering will be discussed in the clinical morning meeting to review and initiate new interventions. Any variance or identified concerns will be addressed immediately. New interventions will be care planned in the morning meeting by the Director of Nursing, Assistant Director of Nursing, or nursing designee. 68). Beginning on 08/13/2021, the Social Services Director or designee will perform random interviews of residents with a BIMS score of eight (8) or greater to ensure they feel safe in the facility and have not been subject to or witnessed abuse. The DON or designee will review random weekly skin assessments for residents with a BIMS score of less than eight (8)	{F 600}		

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{F 600}	Continued From page 149 to ensure no injuries of unknown origin beginning 08/13/2021. Any variance or identified concerns will be addressed immediately. 69). On 08/25/2021, the Registered Dietician conducted audits of resident diet orders from the electronic medical record against orders entered in the diet/tray card software to ensure accuracy. 70). Beginning on 08/23/2021, the Dietary Manager will ensure and audit meals leaving the kitchen and reaching the units timely. Audits will be conducted for random meals twice daily for one (1) week, twice per week for two (2) weeks, and then weekly for one (1) month. Once meal trays arrive at the unit, management staff will assist in passing trays to ensure residents receive meal trays, and certified nursing assistants assist residents promptly. The Dietary Manager or designee will audit the time it takes to pass meal trays to residents after they arrive on the unit beginning 09/11/2021. All three (3) meals will be observed on each unit daily for two (2) weeks, two (2) meals on each unit daily for two (2) weeks, one (1) meal on each unit daily for four (4) weeks. 71). The dietary manager or designee will review admitted/re-admitted residents' food and beverage preferences within 72 hours of admission and enter them into the diet/tray card system for listing on their tray cards beginning 09/16/2021. Review of food preferences will be completed bi-annually and as needed for all residents. Physician-ordered snack intakes will be audited by the Dietary Manager daily for one (1) week, weekly for four (4) weeks, and monthly after that for four (4) months beginning 09/15/2021.	{F 600}		

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{F 600}	Continued From page 150 72). Daily COVID-19 screenings for staff will be audited beginning on 08/25/2021 by the Human Resources (HR) Director against time clock punches to ensure screening before beginning their shift. Audits will be completed Monday through Friday for four (4) weeks by the HR Director, and weekends audited on Mondays. Any staff not screened will be re-educated immediately on the COVID-19 Screening Policy by the HR Director. The HR Director was educated on the COVID-19 policy by the Regional Nurse, an infection control preventionist. All entry doors will remain locked. Visitors must be allowed entry by staff and screened by staff at the time of entry. 73). Beginning on 09/17/2021, the DON and/or designee will round seven (7) times each week for eight (8) weeks, five (5) times weekly for four (4) weeks to audit infection control compliance on differing shifts and units. Audits will include observation of handwashing; isolation signage and zones; donning/doffing (putting on/taking off) PPE; and mask compliance. Any variance or identified concerns will be addressed immediately by the auditor. 74). The DON, ADON, and/or Designee will review all residents on narcotics with the pharmacy to ensure an active script is on file beginning 09/23/2021. Staff will notify the physician within two (2) days of the prescription's expiration. 75). The Regional Nurse Consultant, Pharmacy, and/or Director of Nursing will conduct random medication pass observations effective 09/25/2021 on random shifts daily until immediate	{F 600}		

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{F 600}	Continued From page 151 jeopardy removed to ensure timeliness and accuracy of medications. The facility utilized the CMS Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. 76). Beginning 09/25/2021 Monday through Friday, the DON, ADON, and/or Designee will audit medication delivery tickets against ordered medications daily to ensure that all narcotics needing a renewal have been sent to the pharmacy. Audits will continue until the Immediate Jeopardy is removed. 77). Beginning 09/11/2021, the Administrator and/or DON will be responsible for monitoring nursing staff daily for four (4) weeks to ensure adequate staffing is maintained. 78). Beginning 09/11/2021, the Administrator and Dietary Manager will be responsible for reviewing dietary staffing daily for four (4) weeks to maintain adequate staffing. 79). Beginning 09/11/2021, the Divisional Vice President of Operations and/or designee will monitor and audit the Administrator daily for 30 days to ensure compliance. 80). Visual rounding will be conducted beginning 09/23/2021 to monitor for residents' change of condition and identification of need for "Stop and Watch" (change of condition) communication. 81). Beginning 09/11/2021, the Administrator or designee performed interviews of residents with a BIMS score of eight (8) or greater to ensure they felt safe in the facility and had not been subjected to or witnessed abuse. No residents had any	{F 600}		

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{F 600}	Continued From page 152 concerns. Interviews will continue to be conducted of residents by the Administrator or designees weekly until immediate jeopardy is removed. **The State Survey agency validated the facility's actions to remove the Immediate Jeopardy on 09/26/2021 as alleged by : 1). Review of Head-to-Toe Skin Assessments revealed staff assessed all residents in the facility on 09/11/2021. A review of the skin assessments revealed eight (8) residents (Residents #65, #324, #45, #14, #357, #27, #74, and #358) had current pressure ulcers with a total number of pressure injuries of twenty (20). A review of the comprehensive care plans for Residents #65, #324, #45, #14, #357, #27, #74, and #358 revealed staff updated the care plans to reflect the resident's current pressure injuries. The facility completed the review on 09/17/2021. A review of the facility's census on 08/28/2021 revealed staff assessed all residents at risk for pressure ulcers with the Braden Scale. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed head-to-toe skin assessment on all residents on 09/11/2021. She further revealed that the facility identified twenty (20) total pressure injuries. She further stated that the facility completed the Braden Scale assessments on all residents on 08/28/2021. Continued interviews revealed the Interdisciplinary Team utilized the skin assessments and Braden Scale assessments to update the residents' care plans. She stated that Resident #65, #324, #45, #14, #357, #27, #74 and #358's care plans were updated to reflect current pressure injuries by 09/17/2021. Interview	{F 600}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185256	A. BUILDING _____ B. WING _____	R 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 600}	Continued From page 153 with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed she updated all residents' care plans to reflect current pressure injuries by 09/17/2021. In addition, she completed a review of walking rounds on 09/15/2021 with Therapy Personnel, the Registered Dietician, the Medical Director, the DON, and the MDS Nurse for Residents #65, #324, #45, #14, #357, #27, #74 and #358. A review revealed the Interdisciplinary Team reviewed each resident's orders, current skin breakdown, care plan, and implemented changes as needed. 2). Review of Resident #65's medical record revealed the Medical Director assessed the resident on 08/25/2021 at 1:45 PM and noted a Stage four (4) pressure ulcer on the sacrum; a deep tissue injury (DTI) to the left and right heels; and a skin tear to the left inner leg. Review of Resident #65's wound care note dated 08/26/2021 at 9.00 AM, revealed the sacrum wound measured, "13 cm (centimeter) (length) by 12.3 cm width and 0.2 cm depth with undermining at 10 o'clock measuring 2 cm and undermining at 12 o'clock that measures 1 cm, muscle exposed. No palpable bone, slough is present, partially removed with wound cleanser." The facility continued to treat the resident's sacral pressure ulcer with Aquacel Ag. A review of a wound evaluation completed on 09/15/2021 revealed Resident #65 had six (6) pressure ulcers, including a stage two (2) to the left superior calf measuring 1.2 cm (length) by 1.4 cm (width) by 0.1 cm (depth), stage one (1) to the right hip measuring 2.5 cm by 2 cm by less than 0.1 cm, stage two (2) to left hip measuring 1.2 cm by 0.8 cm x less than 0.1 cm, stage two (2) to left scapula measuring 1 cm by 0.2 cm by less than 0.1 cm, unstageable to right heel measuring 0.6	{F 600}		

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{F 600}	Continued From page 154 cm by 0.6 cm. and four (4) areas to the sacrum measuring 12 cm by 11.6 cm by 0.4 cm. Interventions in place for the resident included heel protectors while in bed, diet as ordered, weekly documentation of the wound, an air mattress to bed, nutritional supplements, and turning/repositioning. Observation of wound care for the sacral pressure ulcer on 09/29/2021 at 10:21 AM revealed the wound measured 13 cm by 11 cm by 0.3 cm with a scant amount of drainage and 95 percent granulation tissue. Resident #65 declined would not consent to the observation of other pressure areas. A medical record review revealed that on 09/21/2021 at 2:19 PM, Physician #1 determined the resident's weight loss and wounds were unavoidable. On 09/28/2021, Resident #65's family declined in-house wound care visits. Further review of the record revealed on 09/29/2021, staff notified the physician of the decline in the resident's wound with no new orders. The resident was diagnosed with Failure to Thrive. 3). The facility admitted Resident #355 on 09/10/2021, completed a skin assessment on 09/10/2021, completed a Braden Scale on 09/10/2021, and completed a baseline care plan on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record revealed staff developed the comprehensive care plan on 09/21/2021. A review of Resident #355's re-admission revealed the resident had an admission skin assessment completed on 09/28/2021, Braden Scale on 09/28/2021, and a baseline care plan developed on 09/28/2021. 4). Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40	{F 600}		

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{F 600}	Continued From page 155 PM, Resident #308 on 09/29/2021 at 11:10 AM, Resident #309 on 09/29/2021 at 11:26 AM, Resident #311 on 09/29/2021 at 11:52 AM, Resident #314 on 09/29/2021 at 11:30 AM and Resident #320 on 09/29/2021 at 11:13 AM revealed the residents appeared clean, well-kempt, and clean linens were on the residents' beds. Interviews with the residents during the time of the observations revealed no identified concerns. A review of Progress Notes for Residents #45, #65, #308, #309, #311, #314, and #320) revealed the Interim Social Service Director interviewed the residents on 09/15/2021 and had no concerns with resident hygiene. Interview with the ISSD on 09/30/2021 at 2:23 PM revealed she interviewed Residents #45, #65, #308, #309, #311, #314, and #320 on 09/15/2021 with no identified concerns regarding hygiene. 5). Observation of residents during the initial tour on 09/28/2021 from 1:33 PM to 2:32 PM revealed no identified concerns. Interviews and record reviews revealed Residents #45, #65, #308, #309, #311, #314, and #320 each had their shower preference and hygiene preference obtained and included on their care plan. A review of the resident's medical record, including the comprehensive care plan and SRNA care plan, revealed staff updated each resident's plan to reflect the resident's preference. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM revealed she assisted with obtaining resident preferences. She stated each resident was interviewed for shower and hygiene preference, and the facility updated each resident's care plan. A review of resident interviews revealed their shower/hygiene preference was obtained. A review of the facility's shower schedule revealed that the resident	{F 600}		